Medical Economics

January, 1956

The Doctor as a Social Animal

... in this issue: Who Says Surgeons Are Getting Rich? • 'Your Best Malpractice Defense' • Licensure: It's a Mess!

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JANUARY, 1956

Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS

SPECIAL FEATURES

MORE ►

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SPECIAL FEATURES (*Cont.*)

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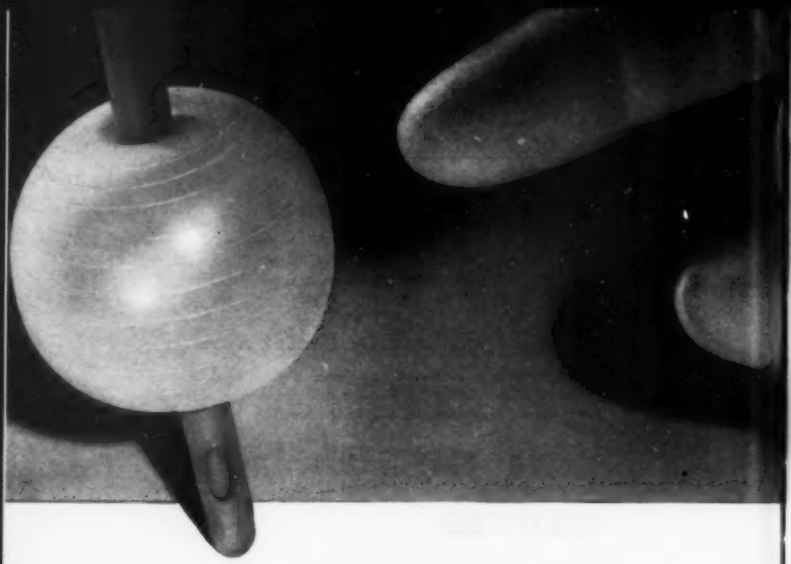
YOUR FINANCES

MORE ▶



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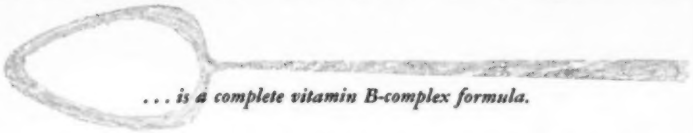

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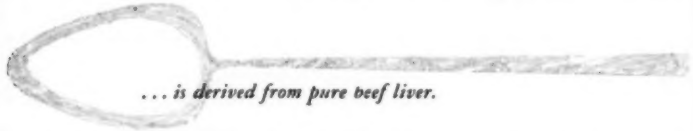

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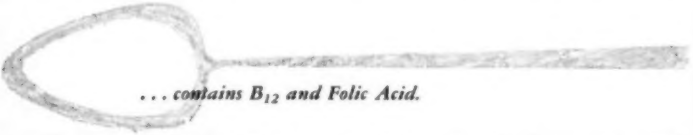

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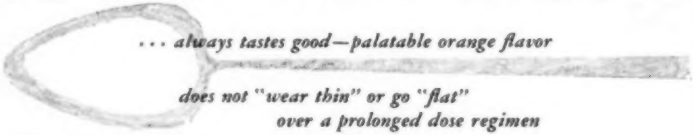

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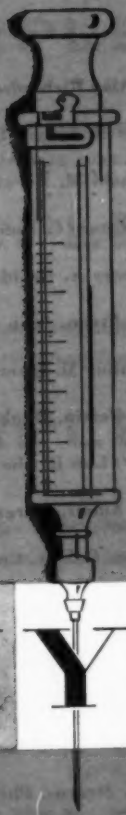

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News

Labor health plans are mushrooming • G.P.s seek fair play within organized medicine • Blood banks to be coordinated • Court test won by salaried specialists • Civil defense need: a radio in your office • M.D.s defend D.O.s

A.C.S. Probing High Surgical Fees

The American College of Surgeons has decided to investigate allegedly excessive surgical fees. It's making the study, says Dr. I. S. Ravdin, chairman of the college's Board of Regents, for two reasons:

1. There have been a number of complaints from the public about high fees;

2. The A.M.A.'s Truman Committee report indicates that fee splitting is still prevalent, despite the college's three-year campaign against it.

Public complaints are serious enough, says Dr. Ravdin, to indicate a close tie between too-high fees and ever-worsening doctor-patient relations. "We're convinced that excessive fees are partly responsible for this situation," he adds. "We intend to get at the facts."

What, if any, action the A.C.S. will eventually take depends on the findings of its investigating committee. Warns Dr. Ravdin: "We do not intend to police American medicine, but it is the function of the [A.C.S.] to see that the public interest is protected as far as Fellows of the college are concerned."

Joint Commission Is Flayed Again

Criticism of the Joint Commission on Accreditation of Hospitals is apparently on the rise. Latest blast comes from Dr. Lewis A. Alesen, who's just completed a three-year term as chief of staff of the Los Angeles County General Hospital.

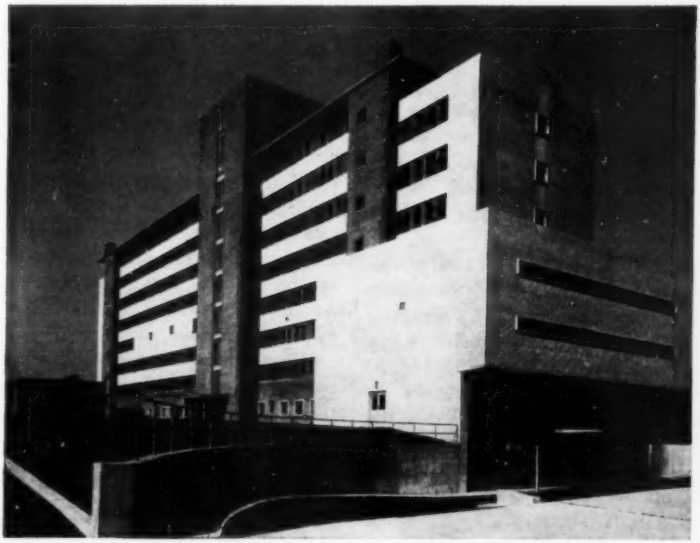
The commission, he charges, puts "emphasis upon form rather than upon substance, upon effort rather than upon result, upon compliance with multitudinous and perfectly useless and futile details at the expense of intelligent, conscientious and productive achievement." He likens its "so-called hospital standardization program" to "bureaucratic marihuana which now grows wildly and without control."

Dr. Alesen objects particularly to

the commission's insistence on "voluminous and complicated" hospital records.

There are, he insists, only two "justifiable" reasons for keeping such records: "(1) to enable . . . all personnel to render the best possible care to the patient; and (2) to protect the physician and the hospital against unwarranted suits for malpractice." But under present commission-enforced requirements, "our

Haunted Hospital



● Many hospitals stagger under heavy patient loads. But not Philadelphia's 284-bed Mercy-Douglass Hospital. Erected over a year ago, the sleek, $3 million building is still unoccupied. Why can't it open? Because it can't get enough money to meet its projected operating expenses. Public donations don't meet its needs; it expects too many nonpaying patients to be able to support itself; and an $880,000 appropriation bill gathers dust in the State Senate while Republicans and Democrats wrangle over the Governor's proposed tax program. Just when the gleaming structure will open is still anybody's guess.

DR. LEWIS A. ALESEN

'Cumbersome, complicated, costly'

complicated charts with their multiple entries can and often do form a happy hunting ground for the skillful lawyer." What's more, he asserts, they increase the patient's bill by 10 to 20 per cent.

Furthermore, the doctor says, the "depths of absurdity . . . seem to have been reached in the matter of compulsory attendence" at the hospital staff meetings. To meet the commission's current requirements, he says, the Los Angeles County Hospital would need a hall large enough to accommodate 900 physicians. There's no such hall in the area.

Dr. Alesen's conclusion: Let the practice of medicine be returned to its practitioners. "All of the advantages [of the hospital standardization program] can be achieved at the local level by local staff and administration without the cumbersome, complicated and expensive mechanisms now imposed by the Joint Commission."

Labor Health Plans Spreading Fast

Union welfare plans are multiplying like rabbits. They now cover about two-thirds of the nation's 16 million union members—twenty times more than were covered only seven years ago. More than 11 million American workers now have insurance protection under such plans, reports the Bureau of Labor Statistics.

The protection includes hospitalization benefits for some 88 per cent of the workers, says the bureau. And about 83 per cent also have surgical coverage.

What's more, over three-fifths of the insurance plans are financed entirely by employers. The bureau reports a growing trend toward relieving the employe of *all* welfare costs.

Court Reverses Decision On Enforced Surgery

You may remember the case of Martin Seiferth Jr., the 13-year-old Buffalo, N.Y., boy who was ordered to undergo surgery last year by the Appellate Division of New York's Supreme Court. (See MEDICAL ECONOMICS, July, 1955.) His father had

refused to allow an operation for the youngster's harelip and cleft palate, chiefly because of his belief in the curative power of the "forces of the universe." But the court ruled that the boy should be given treatment for his own sake "over the opposition of the parents."

Now New York's Court of Appeals has overruled the lower tribunal. Says the final decision (reached by a five to four majority of the highest court in the state): "... Less would be lost by permitting the lapse of several more years, when the boy may make his own decision to submit to plastic surgery, than might be sacrificed if he were to undergo it now against his sincere and frightened antagonism."

Car Ornamentation Seen As Hazard to Life

"Thousands of people who are hit by automobiles each year are needlessly killed, disfigured, or maimed as a result of poor automobile grill, bumper, door handle, and hood design." So charges the Traffic Trauma Committee of the California Academy of General Practice.

The committee applauds manufacturers who are now equipping their cars with such devices as safety belts, padded dashboards, and safety locks on doors. But, it warns, the manufacturers haven't gone far enough: "While they are beginning to make interiors safer for passengers, they've completely forgotten

Snapshots

AVERAGE FEE SCHEDULES, long under test in California and Colorado counties, are catching on in the Midwest. The Indiana State Medical Association has asked Hoosier M.D.s to draw up county-wide schedules—and to accept the listed average fees as full payment from all local industrial workers.

NEW SPECIALTY? A recent newspaper announcement that a young doctor was starting practice in a small Connecticut town explained that he would limit his practice to "obstacles and gynecology."

PAPERBACK MEDICINE hits the stands with "Understanding Surgery"—a new book for laymen by Dr. Robert E. Rothenberg. Published by Pocket Books, Inc., it costs only 50 cents and minces no clinical words. Its purpose: to answer all the layman's questions about surgical procedures.

DISGRUNTLED PATIENTS don't always sue for malpractice, a West Coast doctor learned recently, after a pair of surgical scissors were left inside an ulcer patient. The patient's newsworthy comment before undergoing another operation: "I'm sure it was just an honest mistake."

Snapshots

STATE INCOME-TAX AUDITS are becoming much more common. About twelve states now compare the taxpayer's state return with photostats of his Federal return, obtained from Washington.

IS IT ADULTERY for a woman to be artificially inseminated by a donor other than her husband? Because an Illinois court has ruled that it is, an A.M.A. legal adviser now warns M.D.s "not to use this procedure" until the law is clarified.

YOU'RE GOOD BUSINESSMEN—some of you, at least: The New York State Bankers Association reports 106 M.D.s serve on the boards of directors of the state's banks.

MALPRACTICE JUDGMENTS are still climbing. Two new highs for one state alone (California): A San Franciscan, paralyzed by diagnostic tests, was recently awarded $250,000. A month earlier, in San Diego, a plaintiff got $225,000.

DEATH CERTIFICATES must be filled out exactly as the law requires, Louisiana officials warn. They recently took a doctor to court because he'd used blue-black ink, instead of the required black.

the pedestrian when designing the outside of cars."

Adds Dr. Donald G. Thompson, who heads the committee: "If automobile designers would spend only two weeks in an emergency hospital, their consciences would not allow them to design cars with knife-edge visors projecting over headlights, hood ornaments that spear their victims, and bumpers and grills that masticate pedestrians and children on bicycles."

Give and Save

You're well aware that charitable gifts are, within liberal limits, deductible on your Federal income tax return. But do you realize just how little such gifts cost you as a result? The following table, prepared by Business Reports, Inc., shows the actual cost of a $100 gift, if reported on an individual tax return:

For taxable income of:	Cost of gift is:
$ 8,000	$70
10,000	66
12,000	62
14,000	57
16,000	53
18,000	50
20,000	47
22,000	44
24,000	41
300,000 (in case you care)	9

If you fill out a joint return, of course, your contributions will cost you a few dollars more. And if tax

rates are reduced this year, as expected, charitable giving will naturally become more expensive, even on an individual return.

G.P.s Are Urged to 'Take Off the Gloves'

It's high time for G.P.s to "make a belligerent stand for nothing less than fair play within organized medicine." In raising this call to arms, President Rufus Brittain of the Virginia Academy of General Practice points out that "the final tribunal for all our rights is on the floor of the A.M.A." The G.P.s, he maintains, must fight for greater representation in Association affairs.

Writing in the Virginia General Practice News, he charges a lack of fair play within his own state. Virginia has long been represented at the A.M.A. by doctors "who are primarily connected with our two medical schools . . . both [of which] are primarily interested in the specialties." So he urges his colleagues to "take off the gloves, politically speaking, in our state convention and elect one of our own members a delegate to the A.M.A."

Doctor Warns Medical Writers: 'Go Slow'

If you've been working on a medical article, you'll do well to wait a couple of years before publishing it.

Who says so? Dr. Donald C. Collins of Hollywood, Calif., who's

DR. RUFUS BRITTAIN

He seeks more power for G.P.s

DR. DONALD C. COLLINS

What's wrong with doctor-writers?

done plenty of writing himself. At a recent meeting of the American Medical Writers' Association, Dr. Collins went on to emphasize that there are far too many "hastily prepared, poorly organized" articles being printed in the country's medical journals.

Dr. Collins' advice to the aspiring medical author boils down to the following three points:

¶ Make sure your article will present "new knowledge based upon adequate scientific data of proven value. This decision should not be made hastily . . . It takes at least two or more years to prepare and write a worth-while medical article . . . While you are making up your mind whether or not to proceed . . . carefully review the world medical literature for the past fifty years . . . Usually, after a dispassionate review of the literature, . . . you will never write about two-thirds of your proposed medical contributions. Thus, many valuable acres of forest will be preserved."

¶ Keep your article short. "Most great medical discoveries were originally reported in articles of less than 3,000 words . . . I once wrote an article that contained approximately 136 words and one chart. To my astonishment, this brief contribution was reproduced . . . in four other American medical journals and abstracted in six foreign medical pub-

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Nicotinamide	25 mg.
Pyridoxine Hydrochloride	1.5 mg.
Vitamin B_{12}	2 mcg.
Folic Acid	0.1 mg.
Pantothenic Acid	5 mg.
Ascorbic Acid	100 mg.

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lications. This experience argues for the validity of brevity."

¶ Make sure it's clear. After writing the first draft, put it aside for a few months. Then "read it to your wife and see if she can understand its meaning. If she can't, it needs further clarification."

Joint Blood Council Becomes a Reality

At long last, the nation's confused blood-bank situation seems likely to be straightened out. The Joint Blood Council, with headquarters in Washington, D.C., has tackled its mammoth job of coordinating the activities of more than 1,500 U.S. blood banks.

The council is made up of representatives of five organizations with a special interest in the field. One of its main functions will be to replace the American National Red Cross as the official blood-procurement agency in times of emergency.

The new body will run no banks of its own. But it will work with, and help expand, existing local programs. It will also try to work out systems for standardizing cross-matching and typing procedures, for inspecting and accrediting blood banks, for shipping blood from one bank to another with a minimum of confusion, and for encouraging research.

The five organizations represented on the council are the A.M.A., the Red Cross, the American Asso-

ciation of Blood Banks, the American Hospital Association, and the American Society of Clinical Pathologists. Each of these has two members on the policy-making board.

But the A.M.A. is expected to play the key role. Dr. Leonard W. Larson of Bismarck, N.D. (who has also served as chairman of the A.M.A.'s Committee on Blood) heads the new organization. And its chief executive officer is Dr. Frank E. Wilson, who for the past three years has been director of the A.M.A.'s Washington office.

M.D.-Hiring Hospitals Lose Court Test

Hospitals throughout the country that hire pathologists and radiologists, then bill patients directly for these specialists' services, have received a stiff jolt:

An Iowa district judge has ruled that such hospitals in his state are practicing medicine illegally. What's more, he's ruled that the physicians involved are violating the Iowa Medical Code by splitting fees.

The precedent-setting decision confirms a 1954 ruling by Iowa's Attorney General. (See MEDICAL ECONOMICS, May, 1955.) It was to upset his decision that the Iowa Hospital Association started its unsuccessful action against the Attorney General, the State Board of Medical Examiners, and the Iowa Association of Pathologists.

During the thir- [MORE ON 255]

Laxative action . . . *suited to his routine*

Relief of temporary constipation: Agoral is suited to the acutely constipated patient who can neither take time off for a "purge," nor time-out to answer the sudden urge induced by strong laxatives: the head of a one-man business; the executive committed to a day of important conferences; the bus driver on a long haul; people in the theatre, the pulpit, the factory, the home. For all who need relief of temporary acute constipation, pleasant tasting Agoral provides positive results without urgency.

No urgency; evacuation which adjusts to schedule: A dose taken at bedtime almost invariably produces results the following day. Elimination is comfortably achieved by mild, positive peristaltic action, not by violent paroxysms of unrestrained hyperperistaltis.

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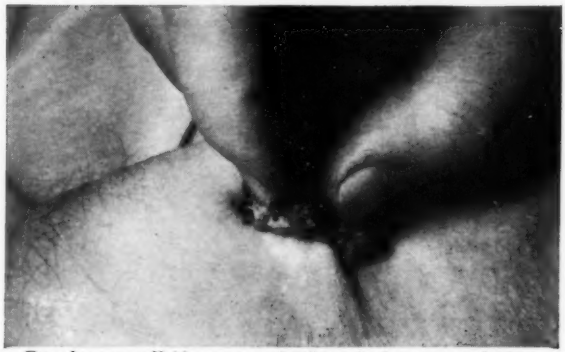

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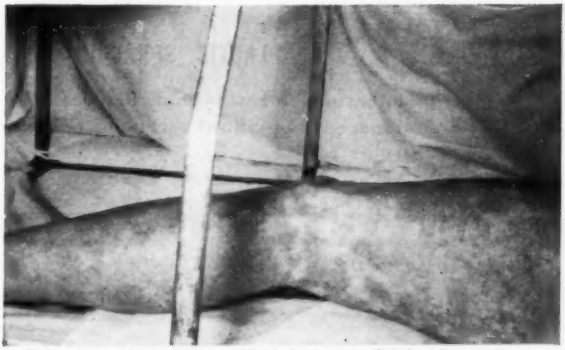

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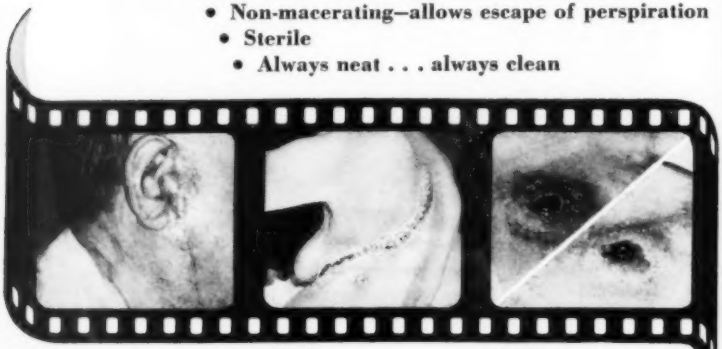

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Laceration (shown above)
Film dressing conforms to hard-to-bandage sites
Scalp wounds
Abrasions and Burns
Skin eruptions

*If hemostasis is complete, use Aeroplast alone. If incomplete, apply one coat of Aeroplast, a layer of gauze, then spray gauze and surrounding skin area with Aeroplast.

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Appendectomy
Herniorrhaphy
Major burns
Vein ligations
Mastectomy
Decubitus ulcers

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To prevent excoriation
To control dermatologic distress, e.g., itching or burning as in sunburn or poison ivy
Under skintight casts
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Contains 55% mineral oil; pleasantly flavored. In bottles of 1 pint.

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KONDREMUL WITH CASCARA
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KONDREMUL belongs in the picture whenever *strain-free elimination* is a "must." The softening and infiltrating action of KONDREMUL results in a soft, well-formed, easily passed stool . . . with no irritation, griping, or tenesmus. KONDREMUL is an outstanding mineral oil emulsion because of its high stability and the extremely small, uniform size of its oil globules, each held firmly in an envelope of Irish moss. No unpleasant leakage.

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Stoneham, Massachusetts

New urethral suppositories relieve pain and fight infection

For the patient, "The treatment is shorter and more comfortable than with the conventional method . . . "*

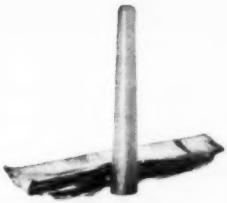
- suppository melts and releases anesthetic agent, to relieve pain and burning *rapidly*
- kills most bacteria common to urinary tract
- easy for patient to insert at home
- *safe*—only occasional irritation in over 340 reported cases*
- *proved*—"The suppository method of medication has proved its worth"*. . . in bacterial (granular) urethritis; for prophylaxis and pain-relief before and after instrumentation.

to prevent cross-infection . . .

FURACIN® vaginal Suppositories are used with Furacin Urethral Suppositories to prevent cross-infection from the vagina • Box of 12.

*Youngblood, V. H.: J. Urol. 70:926, 1953.

EATON LABORATORIES, Norwich, N. Y.



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BRAND OF NITROFURAZONE

urethral
SUPPOSITORIES

Each Furacin Urethral Suppository contains 0.2% Furacin (brand of nitrofurazone) and 2% diperodon HCl in a water-miscible base. Hermetically sealed in silver foil. Box of 12.

NITROFURANS a new class of antimicrobials neither antibiotics nor sulfas

It's not a distress call... not yet... but it could be— For effective appetite suppression in obesity...

AMBAR® Robins

METHAMPHETAMINE AND PHENOBARBITAL

TABLETS AND EXTENTABS®

The "distress call" in obesity often comes from the emotional "misfit," unable to control mood or appetite. Ambar allays this hunger sensation by *gently* lifting the depressed mood, and *subtly* reducing the emotional distresses so often responsible for the urge to overeat. Ambar brings the obese patient's appetite "down to normal"...

...without peaks of stimulation
...without troughs of depression
...without significant cardiovascular effects
...without postmedication "jitters"

AMBAR™ TABLETS

Methamphetamine Hydrochloride . . 3.33 mg.
Phenobarbital (1/3 gr.) . . . . . 21.6 mg.

Average duration of therapeutic effects 4 hours

AMBAR™ EXTENTABS®

Methamphetamine Hydrochloride . . 10.0 mg.
Phenobarbital (1 gr.) . . . . . 64.8 mg.

Average duration of therapeutic effects 10-12 hours

•

Literature available on request.

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A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA

Ethical Pharmaceuticals of Merit Since 1878

an asset to therapeutic diets

Attention to the nutritional requirements of patients effectively supplements medical procedures in helping reduce mortality rates and in shortening convalescence. A state of good nutrition enhances resistance to disease, increases the capacity of tissue for repair, and promotes morale.

Nutritional Advantages

Because of its enrichment and its nonfat milk solids content, the average enriched bread supplies valuable amounts of good quality protein, thiamine, riboflavin, niacin, iron, and calcium. Its protein functions for growth, repair, and maintenance. Its calories help to spare protein for specific protein uses and contribute to energy needs.

The table (right) points up how effectively 6 slices participate in providing good nutrition in illness and convalescence.

Physiologic Advantages

Soft and open in texture, enriched bread is easily masticated and swallowed. It is promptly and thoroughly digested. Its appetizing eating qualities reflexly incite the digestive processes. Producing insignificant amounts of smooth inert residue, it does not irritate the gastric or intestinal mucosa.

Dietetic Advantages

In either fresh or toasted form, enriched bread adds to the eating pleasure of meals. Neutral in flavor, it blends well with other foods. When appetite lags, sandwiches including a wide variety of foods—meat, poultry, eggs, cheese, salad preparations and various spreads—give zest to eating as well as needed nourishment.

These advantages—nutritional, physiologic, and dietetic—establish enriched bread as a valuable asset in therapeutic diets.

Contribution of 6 Slices of Enriched Bread

	Nutrients and Calories	Percentages of Allowances*
Protein	11.7 Gm.	18%
Thiamine	0.33 mg.	22
Niacin	3.0 mg.	20
Riboflavin	0.21 mg.	13
Iron	3.3 mg.	28
Calcium (average)	122 mg.	15
Calories	379	13

*Percentages of daily allowances for 143 lb., 67 in. tall fairly active man of 45. Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953.

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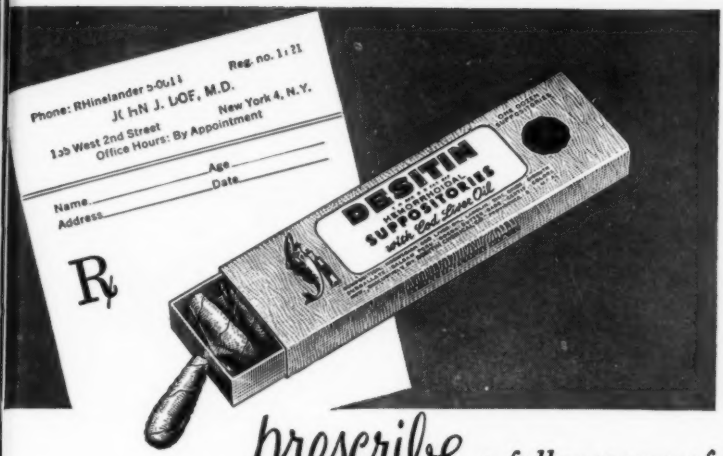
20 NORTH WACKER DRIVE • CHICAGO 6, ILLINOIS

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.



prescribe *a full measure of comfort for anorectal patients with*

DESITIN®

hemorrhoidal SUPPOSITORIES with cod liver oil

In boxes of 12 foil-wrapped suppositories

samples yours for the asking

DESITIN SUPPOSITORIES quickly soothe, protect, lubricate the distressed anorectal mucosa to provide.....

- **gratifying comfort in hemorrhoids** (non-surgical)
- **rapid, sustained relief of pain, itching and spasm without styptics, local anesthetics or narcotics, therefore do not mask serious rectal disease**
- **reduced engorgement, bleeding • safe, conservative**

DESITIN CHEMICAL COMPANY • 70 Ship Street, Providence 2, R. I.

Erythromycin in treatment of abscess

6/21/55

DISCHARGE SUMMARY

On 5/23/55 this patient (colored female, age 24) underwent an excisional biopsy of a breast tumor. On 5/24 tumor was removed and patient discharged from hospital on following day.

On 6/3/55 patient was readmitted because of purulent discharge from wound. On 6/3 a hemolytic Staph. aureus (coag. +) was isolated from abscess with the following disk sensitivities: penicillin, 1.5 units; erythromycin, 10 mcg; tetracycline, 10 mcg. Patient was placed on penicillin, 600,000 units b.i.d. for 10 days. On this schedule patient improved but progress was unsatisfactory and wound continued to discharge small amount of purulent material.

On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

Final diagnosis: breast abscess due to Staph. aureus.

Result: rapid and complete recovery on erythromycin following failure of penicillin.

Communication to Abbott Laboratories.

specific against coccic infections

Now, you can prescribe an antibiotic (*Filmtab* ERYTHROCIN) that provides *specific therapy* against staph-, strep- or pneumococci. Since these organisms cause most bacterial respiratory infections (and since they are the very organisms most sensitive to ERYTHROCIN) doesn't it make good sense to prescribe ERYTHROCIN when the infection is coccic?

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Erythrocin®
(Erythromycin, Abbott)
STEARATE

with little risk of serious side effects

Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to alter intestinal flora—with an accompanying low incidence of side effects. Also, your patients seldom get the allergic reactions sometimes seen with penicillin. Or loss of accessory vitamins during ERYTHROCIN therapy. *Filmtab* ERYTHROCIN (100 and 250 mg.), bottles of 25 and 100. Abbott

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®Filmtab—Film sealed tablets; patent applied for

60H06

Conservative Therapy For Anorectal Distress

RECTAL MEDICONE

relieves painful anal lesions — ulcers abrasions — thrombosed hemorrhoids

■ In serious rectal involvement—where severe pain and discomfort are the patient's chief complaint[1] — the insertion of Rectal Medicone affords dramatic relief, thus enabling the clinician to proceed with therapeutic measures for treatment of the basic condition.

millions prescribed yearly...

[1]*Bargen, J. A., and Jackman, R. J., Journal Lancet, 72:11, Nov., 1952.*

MEDICONE COMPANY • 225 VARICK STREET • NEW YORK 14, N.Y.

Letters

Surgical fee scales • Sharing a second office • Changes in osteopathy • Hospital troubles • Are the 'nonmedical' specialties encroaching? • Blue Shield contracts • Hiring a laboratory technician

Hospital Accreditation

SIRS: The Joint Commission on Accreditation of Hospitals reminds me of Jeremy Bentham, who was certain he could outline a perfect government for India without ever visiting that country. . .

The commission's attempts to limit staff privileges are an unwarranted invasion of local authority. All professional responsibilities should be left to the hospitals and their staffs. They shouldn't be arbitrarily fixed by distant seers who perceive *our* faults but not their own.

Robert J. Needles, M.D.
St. Petersburg, Fla.

SIRS: Jittery hospital administrators, fearful of losing their accredited status, are filling their committees with board men. Most of the board men have little respect for the general practitioner. They think he should stay in his referral office giving innocuous pills. So he's denied staff privileges or relegated to the general practice section—which is usually only for "window dressing."

The G.P. is left with only one recourse: to build his own hospitals. . .

Alfred P. Luppi, M.D.
La Canada, Calif.

Miners' Medicine

SIRS: As you mentioned in your article, "Medicine by the Ton," I've been representing our state medical society in its negotiations with the United Mine Workers Welfare and Retirement Fund. And I believe that both the doctors and the fund's officials are sincere in their efforts to develop a compatible working relationship. Many of our differences have already been resolved.

E. W. Meiser, M.D.
Lancaster, Pa.

SIRS: You said that the U.M.W. "owns no clinics of its own. But it does largely support many physicians who staff private clinics . . ."

Many of the clinics that serve mining communities are *not* private. The ones at Russellton and in Washington County, Pa., were financed by the U.M.W. And their boards of

little

How to win friends ...

The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

15¢ Bottle of 24 tablets (2½ grs. each).

We will be pleased to send samples on request.

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1450 Broadway, New York 18, N.Y.

for the pain and disability of **HERPES ZOSTER**

PROTAMIDE®

(SHERMAN)

published studies show:*

Improvement is "almost immediate," with "good to excellent results" in four out of five patients, and no postherpetic neuralgia in any patient who responded favorably.

Protamide is a sterile colloidal solution prepared from animal gastric mucosa . . . denatured to eliminate protein reaction . . . completely safe and virtually painless by intramuscular injection.

Clinical data on request.

use PROTAMIDE® *first*

in herpes zoster and post-infection neuritis

SHERMAN LABORATORIES
BIOLOGICALS · PHARMACEUTICALS

* Combes, F. C. & Canizares, O.: New York St. J. Med. 52:706, 1952: Marsh, W. C.: U. S. Armed Forces M. J. 1:1045, 1950.

directors are composed almost exclusively of mine workers.

Physicians were ostensibly given their choice of either a fee-for-service arrangement or a salary. But only those who agreed to work on a salary basis were employed.

M.D., Pennsylvania

'Chief of Staff'

SIRS: It's often said that the general practitioner should act as "chief of staff" when a patient is being treated by a number of specialists. The standard reason—and a good one, too—is that he's the only doctor who can coordinate the plans of divergent specialists, and the only one who sees the patient as a whole.

Carrying this line of thought through to its logical conclusion, shouldn't the chief of staff in a *hospital* be a family doctor, for precisely the same reasons?

Henry A. Davidson, M.D.
Cedar Grove, N.J.

Fee Scales

SIRS: In determining the relative values of fees for various operations, we use a different formula from the one described by Dr. William H. Horton in "Set Your Surgical Fees With This Scale." For example, we normally set the values on a time basis only.

Yet our results are very close to Dr. Horton's. Here are the relative point values the doctor lists for some procedures (in the column headed "H"), as compared with those we found recently in a study of one doctor's practice (marked "M"):

	H	M
Appendectomy	12	12½
Cholecystectomy	17	19½
Colon resection	21	21½
Gastrectomy	22	22½
Hemorrhoidectomy	10	15
Herniorrhaphy, bilateral	12	14
Herniorrhaphy, unilateral	11	14
Hysterectomy	17	22

Geoffrey Marks
Porterfield-Marks
Seattle, Wash.

Second Office

SIRS: Your article, "Need a Second Office?" included the following advice: "A number of M.D.s with a second office have found that they make out well by sharing the space—and sometimes personnel and equipment—with another doctor."

True enough—*if* there's a definite financial arrangement that's confirmed in writing. Unwritten agreements too often lead to embarrassment or ill will.

Nelson Young
Professional Management
Detroit, Mich.

Foreign Doctors

SIRS: One of your correspondents accuses many hospitals of giving the foreign house doctor "a multitude of small tasks that leave him little time for study." This hasn't been true of the teaching hospitals

in which I have served. I've found that the *capable* foreigner is given the same responsibility for patient management as his American colleagues.

Of course, the value that a doctor gets out of hospital training depends on the amount of time he spends at the bedside or in the laboratory—*not* in the library. If all the foreign doctor wants is "time for study," he needn't leave home.

M.D., New York

Retirement Plan

SIRS: Several months ago, you published a letter in which I proposed that the A.M.A. set up a retirement haven for doctors in Florida.

I've since learned that it's against A.M.A. policy to assume financial responsibility for any such enterprise. So it will have to be promoted as a private organization by the interested physicians themselves. The response to my letter indicates that it will be.

John Peters, M.D.
Oak Park, Ill.

Tomorrow's Medical Care

SIRS: Your "Visit With Michael Davis" is entertaining. But the author overplays one part of his conversation with me: the part relating to national health insurance.

The implication seems to be that my book, "Medical Care for Tomorrow," is almost entirely concerned with that subject. Readers of the book will find that this is by no means the case. Its main points may be summarized briefly:

1. There is an underlying force that has been changing medical services and the methods of paying for them. This force is the growing knowledge of the preventive and curative benefits of medical science, and the consequent demand that these benefits be made available to all without burdensome costs.

2. To attain this goal, two things are necessary. First, the organization for furnishing medical services must be improved, chiefly by replacing most individual practice by group practice. Second, payment for medical services must be through prepayment by groups of *well* people, instead of through fee-for-service payment by *sick* people.

3. Responsibility for financing medical services rests upon those who receive them. Responsibility for the services themselves rests upon the professions furnishing them.

4. There are two forms of prepayment: insurance and taxation. Both forms are growing rapidly, but taxation leads over insurance. If insurance providing comprehensive services is held back, tax-supported medicine will grow still more rapidly.

Michael M. Davis, PH.D.
Washington, D.C.

About Osteopaths

SIRS: In my opinion, the report of the Cline committee failed to prove that any great evolutionary

change has taken place in osteopathy. Nor do statements from leading osteopaths indicate a trend away from their original philosophy. To the contrary.

The D.O.s seem determined to resist such a trend, whether originated by members of the A.M.A. or by some in their own group.

James M. Kolb, M.D.
Clarksville, Ark.

SIRS: ... We're told that the osteopaths are practicing medicine poorly, and that amalgamation will enable us to teach them how to practice *good* medicine.

If this reasoning is cogent, the A.M.A. should also open its ranks to chiropractors, naturopaths, Christian Scientists, and witch doctors. (We have quite a few of the latter in this region.)

Norman M. Hornstein, M.D.
Southport, N.C.

Buying Life Insurance

SIRS: You recently published a letter implying that it was a mistake to do business with any life insurance company not licensed in New York State. Your physician-correspondent said that New York has "the most stringent laws regarding insurance company investments and commissions."

As medical director of the American United Life Insurance Com-


steady as she goes!
. . . off to a wonderful start in Stride Rite Firsties, made with broad heel seats and snug-fitting heels, firm counters, sturdy flexible soles, soft supple upper leather . . . and made with famous Stride Rite fit, too.
In Stride Rite Firsties . . . and other "beginner" shoes . . . you will find the features considered most essential in the important early walking years. You'll find, too, the same skilled workmanship and quality materials that distinguish all Stride Rite shoes . . . and for which most doctors who know Stride Rites recommend them.
THE STRIDE RITE SHOE
Green Shoe Mfg. Co., Boston, Mass.
doctor:
If you are not already familiar with Stride Rites, and with Stride Rite Shoes with Extra Support, write for information to: Green Shoe Mfg. Co., 960 Harrison Ave., Boston, Mass.

pany, I'd like to point out that Best's Life Insurance Reports ranks many companies that aren't licensed to sell in New York State higher than some that are. And there *are* New York companies that Best's doesn't recommend at all!

John S. Pearson, M.D.
Indianapolis, Ind.

Says a spokesman for Best's: "Dr. Pearson is correct. Many of the companies that don't operate in New York State are well managed and financially sound. For many reasons, they may never have applied for New York licenses; but this is no reflection on their reliability."—ED.

What Ails Hospitals?

SIRS: "What Ails Our Hospitals?" is at least 90 per cent correct. And it expresses the views of most of the medical staff at my hospital.

Nowadays, the physician finds it futile to complain if the nursing care seems poor, the diet unsatisfactory, or the room dirty. He soon finds that he's considered much more expendable than the nurse, the dietitian, or even the janitor . . .

M.D., New York

SIRS: As chairman of the board of trustees of the Washoe Medical Center, and as a long-time member of its medical staff, I'd like to say a word in defense of hospital administrators. To begin with, consider this quotation from the article: "The Joint Commission . . .has especially

strengthened the administrator. For one thing, it has enormously increased the importance of records—an administrative function."

But the Joint Commission is composed primarily of doctors. Members of the American Hospital Association are in the minority. So it has been mainly *doctors* who have stressed the importance of good medical records.

The author of your article seems not to know about the shortage of nurses. He takes no cognizance of the fact that in the past ten years hundreds of new hospitals have been opened—and have had to be staffed. All the additional categories of hospital help that the author derides have been added in order to give the nurses more time for their patients...

My hat is off to those thousands of administrators who have kept their hospitals equipped, maintained, and staffed in these days of increasing costs.

Ernest W. Mack, M.D.
Reno, Nev.

'Nonmedical' Specialties

SIRS: Until I read Dr. Robert W. Johnson's article, "Optometry Wants to Halt M.D.-Refracting," I had assumed that all doctors had a background of medical history. But Dr. Johnson writes as if refraction were a medical field that others are attempting to take over. Actually,

it started as a *nonmedical* specialty, which the M.D.s are now trying to pre-empt . . .

The medical refractionist is perpetrating a colossal hoax. He extracts money for something that his training never covered and that his state board never checked him on.

Loran Hendrickson, O.D.
Grand Forks, N.D.

SIRS: Dr. Johnson refers to chiropody as one of the "nonmedical" specialties that are infringing upon the "areas of medical care traditionally reserved to the licensed M.D." As a chiropodist, I'd like to point out that my profession arose as a result of neglect of the feet by M.D.s.

Granted, a few physicians and many orthopedic surgeons understand and treat *major* foot problems. But they usually neglect "minor" complaints stemming from corns, calluses, and ligament strains.

I don't mean this as a condemnation of the M.D. He's a busy man . . . But we're a proud group filling a real need. We resent being accused of encroachment.

Merton L. Root, D.S.C.
San Jose, Calif.

Military Medicine

SIRS: In a recent news item, you reported that far too few doctors are taking up careers as military men. One reason for this is suggested by


Stan Ekman

a conversation I had in the Army in 1943.

The assistant chief of medicine said to me: "Maybe I shouldn't tell you this, but you'll find it out anyhow. The Army doesn't give a damn what you do with patients. But for Heaven's sake, keep your paper work straight!"

W. R. Arrowsmith, M.D.
New Orleans, La.

Patients' Rights

SIRS: Some of the regulations laid down by the Joint Commission reflect no understanding of the family doctor's problems. As a result, he sometimes isn't free to do what's best for his patient.

For instance, sterilization used to be a simple matter. During an intra-abdominal operation, the doctor would ligate the tubes, simply because "the patient wanted and needed it done." But it's now practically mandatory that two M.D.s consult on any sterilization.

In addition, the hospital superintendent has to check for hospital liability. The operating-room supervisor must verify the signatures. The records committee has to approve the procedure, which can be done for medical reasons alone. And the list of medical reasons gets shorter every year . . .

I think that people are sufficiently enlightened nowadays to know their

for the treatment of

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the most practical and generally satisfactory progesterone dosage form

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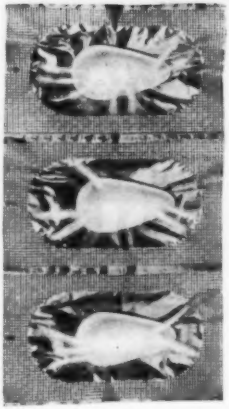

More acceptable
Avoids pain and inconvenience of injection . . . insures better patient cooperation than any other dosage form.

More dependable
Response is more predictable than with oral, or buccal and sublingual therapy.

More economical
Cost is low in terms of greater patient benefits.

"Colprosterone" Vaginal Tablets — Brand of progesterone U.S.P. presented in a specially formulated base to insure maximum absorption and utilization.

Complete dosage regimens for above indications as well as for premenstrual tension and lobular hyperplasia are outlined in descriptive literature. Write for your copy.

Supplied: No. 793—25 mg. tablets (silver foil), boxes of 30.
No. 794—50 mg. tablets (gold foil), boxes of 30.

Each tablet is individually and hermetically sealed. Presented in strips of 3 units, detachable as required.

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Ayerst

own minds. When they come to their family doctor, having decided to be sterilized, aren't they entitled to this simple, minor operation? Procreation is a blessed thing, but why run it into the ground?

John M. Hoffman, M.D.
McMinnville, Ore.

Help in Economics

SIRS: Congratulations on the recent Memo From the Publisher pointing out that "the doctor needs all the economic education he can get." I certainly agree.

Like medical problems, economic problems are more complex today than they used to be. Yet the young doctor gets little more instruction in medical economics than students got years ago.

It would be a good idea for some organization to promote monthly group discussions of business topics among medical students.

Better still would be special medical-school courses in accounting, taxes, office procedures, insurance, and so on.

William R. Hunt
Management Service for Doctors
Waco, Tex.

Blue Shield Contracts

SIRS: I'm afraid it will be a long time before Indiana doctors are ready to accept a service contract. The reason is given in "Blue Shield

A New Cough Preparation little patients really like—

(and its high gastric tolerance repays their confidence!)

Vicks Medi-trating Cough Syrup is a new non-narcotic cough mixture with specialized characteristics designed to produce relief of coughs of colds by two mechanisms. It works direct by coating and soothing the irritated membranes to relieve coughs originating in the throat area. Containing Cetamium (Vick brand of cetylpyridinium chloride), the mixture has increased spreading and penetrating properties which enhance its local antitussive action.

Containing two effective expectorants—ammonium chloride and sodium citrate—it produces rapid non-irritating action. It has a high degree of gastric tolerance and palatability which makes it acceptable to both adults and children.

Active Ingredients: Sodium Citrate, Ammonium Chloride, Glycerin, Cetamium (Vick brand of cetylpyridinium chloride) in a pleasantly flavored syrup containing Eucalyptus, Menthol, Camphor, and other Vick aromatics.

VICKS
MEDI-TRATING
COUGH SYRUP

Made by the makers of Vicks VapoRub

LETTERS

Faces Its Hour of Decision," by James E. Bryan: "If a Blue Shield plan thinks a tonsillectomy is worth only $25, why should anyone pay more?"

Unless service-plan fees were raised to the level of the city specialist's charges, they would tend to cheapen all medical service to the Blue Shield low.

William C. Reed, M.D.
Bloomington, Ind.

SIRS: ... The ideal situation would be a service-type contract with an adequate fee schedule for all classes of patients, and without any fixed income ceiling.

Such a plan is being tried on a limited scale by California Physicians' Service. Their so-called "B" plan has a higher income ceiling ($6,000) and a fee schedule that's in line with fees actually charged in private practice.

But it remains to be seen whether this plan will work out and whether it can be broadened to include a larger segment of the population. From the standpoint of the physician, it should be ideal. From the standpoint of the patient, the premiums may be too high to make it attractive.

In any event, I believe it's a step in the right direction.

Edward K. Blasdel, M.D.
Berkeley, Calif.

SIRS: ... Some way should be found to enroll doctors' secretaries as a group in Blue Shield, Blue Cross

Most useful antibiotic for the most prevalent infections.

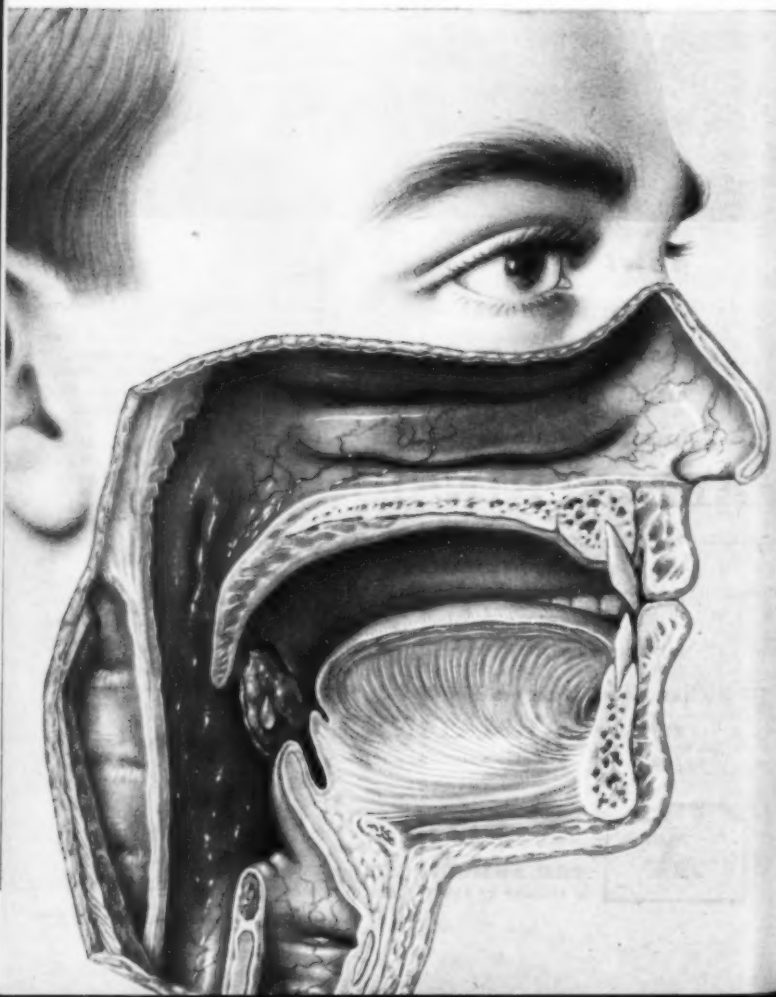

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Table

Eli Li

ILOTYCIN

(ERYTHROMYCIN, LILLY)

Over 96% of all acute bacterial infections of the respiratory tract are caused by organisms highly sensitive to 'Ilotycin.'

The most effective antibiotic against staphylococci.
More than 90% of all staphylococci encountered in private practice are highly sensitive to 'Ilotycin'—more than to any other antibiotic.

More effective against streptococci than the tetracyclines.
'Ilotycin' is bactericidal. The great majority of throat cultures become negative within twenty-four hours. Thus, the possibility of complications is minimized.

Fully as effective against pneumococci as any other antibiotic.
In pneumococcus pneumonia, fever and acute symptoms subside within forty-eight hours. The pneumococcus-killing action of 'Ilotycin' is especially desirable in elderly patients and in debilitated states.

Safe and well tolerated.
Serious hypersensitivity reactions, staphylococcus enteritis, and avitaminosis have not been encountered.

Dosage: 250 to 500 mg. q. 6 h.

Children, 5 mg. per pound of body weight q. 6 h.

Tablets, pediatric suspensions, drops, I.M. and I.V. ampoules.

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DOCTOR, RY-KRISP'S LOW CALORIE CONTENT HELPS EXPECTANT MOTHERS AVOID EXCESS WEIGHT.

insurance plans. The only way we can get protection now is by paying the higher rates for individual enrollments.

M.D.'s Aide, Massachusetts

Lab Technicians

SIRS: I'd like to pass along a few necessary words of caution to readers of Ben L. Loventhal's recent article, "Does a Laboratory Technician Pay Off?":

I've been a pathologist for over thirty years. During that time, I've observed the work of girls who've had a smattering of laboratory training, either in medical secretarial schools or on the job. And it's my opinion that any doctor who relies on the accuracy of their work is looking for trouble . . .

A doctor in a small rural community might have certain *simple* laboratory procedures done in his office, if otherwise he'd have to do without them entirely. But he himself should first get enough training to be able to check his technician and to interpret her findings.

Asher Yaguda, M.D.
Newark, N.J.

SIRS: . . . Your article didn't mention the American Medical Technologists, which has about 12,000 laboratory technicians on its register. This organization maintains a large placement service, through which many

MERELY SKIN-DEEP

"obesity...may predispose its victims to heart disease, diabetes, liver disease, and other complications."[1]

A progressive organic deterioration occurs in overweight persons, which is of far greater medical significance than the more obvious outward changes in appearance.

SYNDROX® HYDROCHLORIDE

METHAMPHETAMINE HYDROCHLORIDE, McNEIL

—suppresses the appetite and thus helps to prevent over-eating in the obese patient.

—imparts a feeling of well-being in the obese patient who otherwise overeats to satisfy frustrated "cravings."

5 mg. tablets (scored, green), bottles of 100 and 1000; also available in a pleasant-tasting elixir (colored amber); each 5 cc. (one teaspoonful) containing 5 mg.—pints and gallons. Samples supplied on request.

1. Armstrong, D. B., Dublin, L. I., Wheatley, G. M. and Marks, H. H.: Obesity and its Relation to Health and Disease, J.A.M.A. *147*:1007 (Nov. 10) 1951.

IC. PHILADELPHIA 32, PENNSYLVANIA

physicians and hospitals obtain qualified technologists.

C. A. Bartholomew, SC.D.
Red Bank, N.J.

Committee Work

SIRS: After reading Dr. Russell B. Roth's article, "Medical Politicians Don't Run *This* Society!" I'm glad I don't practice in Erie County, Pa.

So the society sends out newspaper releases "complete with glossy prints" of its new members, does it? And the new man is included on a TV presentation, is he?

What goes on, anyhow? Is this medical practice or the sale of pickles?

"Each doctor," says Dr. Roth, "receives a list of our committees . . . It's mandatory that he choose at least one." I wonder if the Soviet medical societies have thought of *that* way to get slave labor! . . . This may be a western Pennsylvania idea of how a professional society should operate. But in eastern Pennsylvania we think it sounds more like a public relations office operated by a hyperthyroid manager.

M.D., Pennsylvania

Health Donations

SIRS: You recently published a chart showing the discrepancy between the number of cases of various diseases and the amount of money collected from the public for fighting them. From your comment, it's clear that you find the discrepancy disturbing.

But should the incidence of a disease be the only factor governing the amount needed to combat it? It seems to me that the most important consideration should be this: How much can be accomplished with the dollars, especially from the standpoint of restoring an afflicted person to usefulness?

With this in mind, I believe your chart indicates that the money is being distributed more wisely than I had suspected . . .

Arthur A. Mickel, M.D.
Cassville, Mo.

Malpractice Mistakes

SIRS: As legal counsel for the California Medical Association, I've observed that most malpractice cases start because of a *nonmedical* mistake by the doctor. The examples you cited in "Safe From Suits? Test Your Vulnerability," bear this out.

Howard Hassard, LL.B.
San Francisco, Calif.

Artificial Insemination

SIRS: Your article, "Let's Talk About Artificial Insemination," is superb. . .

Even when the law is clear in a case involving artificial insemination, it's usually a jury that must make the final decision. And all too often the jury is incapable of understanding and evaluating the issues concerned.

Willard R. Cooke, M.D.
Galveston, Tex.

END

CHECK THE DISEASES MET WITH

- ☐ Problems in obstetric management (1-5)
  spontaneous abortion—early and late, postpartum hemorrhage, prophylaxis—prenatal care and lactation
- ☐ Diseases of the cardiovascular system (6-12)
  cerebrovascular diseases, hypertension
- ☐ Diseases of the blood (13-21)
  vascular purpuras, idiopathic purpura, leukemias
- ☐ Diseases of metabolism (22-24)
  diabetes and diabetic retinopathy
- ☐ Infectious diseases (25-27)
  rheumatic fever, tuberculosis, leprosy, poliomyelitis
- ☐ Ophthalmological diseases (43-45)
  ocular hemorrhage, retinal vascular lesions, pre-retinal edema, chorioretinitis
- ☐ Diseases requiring Roentgen therapy (28)
- ☐ Diseases requiring anticoagulant therapy (29-30)
- ☐ Diseases of the locomotor system (31-34)
  rheumatoid arthritis
- ☐ Toxicity due to chemical agents (35)
  antisyphilitic therapy, arsenicals, bismuth and antimony compounds, benzene, sulfonamides, salicylates, gold salts, diethylstilbestrol
- ☐ Diseases of the kidneys (46)
  hematuria and hemorrhagic nephritis
- ☐ Diseases of the respiratory tract (36)
- ☐ Diseases of nutrition (28)
  telangiectasis
- ☐ General Adaptation Syndrome (47)
  stress
- ☐ Diseases of allergy (18) (20) (42)
  bronchial asthma, allergic purpura
- ☐ Dermatological diseases (37) (42)
  eczema, psoriasis
- ☐ Fractures (48)
- ☐ Surgery (49-50)
  disruption of wounds

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for your tense peptic ulcer patients

new
ANTRENYL® - PHENOBARBITAL

depresses... ... gastrointestinal motility

... gastric acid secretion

... nervousness and irritability so common in the ulcer diathesis

SUPPLIED: Antrenyl-Phenobarbital Tablets (scored), each tablet containing 5 mg. Antrenyl and 15 mg. phenobarbital.

Other forms: Tablets, 5 mg. Syrup, 5 mg. per 4-ml. teaspoonful. Pediatric Drops, 1 mg. per drop.

Antrenyl® bromide (oxyphenonium bromide CIBA)

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You'll appreciate the convenience and practical design of these new instruments by Bausch & Lomb. They're completely redesigned. Features include: lightweight die-cast aluminum heads, positive-locking bayonet type handle connections; brilliant flicker-proof lighting from pre-focused lamps; and positive thumb-tip control of light intensity. Weight, balance and finish—all contribute to a new luxury "feel". Your supplier will show them to you —or write: Bausch & Lomb Optical Co., Rochester 2, N. Y.

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SINCE B&L 1853

The safe, six-way attack on

intranasal infection

'Trisocort' Spraypak*

1. Hydrocortisone	To reduce inflammation, edema and engorgement.
2. Gramicidin	Specific against gram-positive bacteria.
3. Polymyxin	Strikingly effective against gram-negative bacteria.
4. Neomycin	Bacteriostatic *and* bactericidal against both gram-positive and gram-negative bacteria.
5. Phenylephrine hydrochloride	For rapid onset of decongestion.
6. Paredrine† Hydrobromide	For prolonged decongestion.

SAFETY. 'Trisocort' is *safe* because of the low concentrations of its components. But despite their low concentrations, Trisocort's ingredients work together to form the ultimate in intranasal therapy. 'Trisocort' has proved useful to a great many physicians, including a few who at first were skeptical. A trial with it—even in your youngest patients—will convince you, too.

Trisocort*

Anti-inflammatory, Decongestive, Antibacterial

Smith, Kline & French Laboratories. Philadelphia 1

*Trademark
†U.S. Reg. U.S. Pat. Off. for hydroxyamphetamine hydrobromide, S.K.F.

the newest concept
in the relief of
selected cases of

SIMPLE "COLDS",
PHARYNGITIS,
TONSILLITIS, INFLUENZA,
BRONCHITIS

based on the occurrence of a
"capillary syndrome"
in such respiratory conditions

Several investigators[1-4] have suggested that citrus bioflavonoid compound, specifically C.V.P., may act as an aid in the relief of fever, coughing, sneezing, copious nasal discharge, and inflamed mucosa in certain respiratory conditions. The writers indicate that a "capillary syndrome" occurs in such conditions — the capillaries are abnormally permeable and fragile. C.V.P. acts to promote normal function of capillaries by helping to restore the integrity of the intercellular ground ("cement") substance of capillary walls.

C.V.P.®

(Citrus Bioflavonoid Compound with Vitamin C)

Each C.V.P. capsule or teaspoonful (5 cc.) of syrup provides:

Citrus Bioflavonoid Compound . .	100 mg.
Ascorbic Acid (vitamin C)	100 mg.

C.V.P. advantages: C.V.P. provides the active capillary protectant factors of whole citrus bioflavonoid compound (sometimes known as "vitamin P complex"), not just a single factor. C.V.P. is water-soluble and thus more readily absorbed than relatively insoluble rutin or purified hesperidin.

Bottles of 50, 100, 500 and 1000 capsules
4 oz., 16 oz. and gallon syrup

SAMPLES and literature[1-4] on request

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250 East 43rd Street, New York 17, N. Y.

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when they don't eat enough

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or won't eat in balance

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here's a new way to help them

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outgrow their clothes ... and ...

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perk up their lagging appetites

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delicious melt-in-the-mouth flavor, too

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STIMAVITE* TASTITABS*

for growth

Each STIMAVITE Tastitab contains:

Vitamin B_1 . . . . . 10 mg.
Vitamin B_6 . . . . . 3 mg.
Vitamin B_{12} . . . . . 20 mcg.
Vitamin C (as Sodium Ascorbate) . . . . 25 mg.
L-lysine . . . . . 15 mg.

Dosage: One tablet daily as a dietary supplement. The tablet may be swallowed whole, allowed to melt in the mouth, or can be dissolved in fluids.

Supplied: Bottles of 30 tablets.

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...in antibiotic therapy are revealed by current reports on

Tetracyn*

Pfizer-discovered tetracycline

Tetracycline is notable among broad-spectrum antibiotics for its solubility and stability. And, clinical trials have established that tetracycline is an efficient antibiotic against those diseases due to susceptible microorganisms.

Now available with the best taste in broad-spectrum therapy

Tetrabon*

homogenized mixture

Newest liquid form; unusual fruit flavor; standardized at Pfizer Laboratories. Each 5 cc. teaspoonful supplies 125 mg. tetracycline. Bottles of 2 fl. oz., packaged ready to use.

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DID you ever stop to think that the many men and women who have a hand in the fabrication, assembly, testing, etc., of equipment you purchase are, in a very major way, responsible for its performance in your practice?

That is why wise manufacturers today consider strongly the *personal equation* along with such requirements as high quality purchasing and production control.

WHO PROFITS

when you buy a Viso-Cardiette?

There's a good reason why, at Sanborn Company, the employees who make the Viso-Cardiette are *concerned* with the manner in which the instruments provide, or do not provide, the service for which the purchase is made. For, when the company makes a profit *they receive a substantial share of it!* This has been going on *since 1917.* Also, the great majority of these same men and women *own* Sanborn Company, being stockholders as well.

It follows that an employee who has a definite stake in the instruments his company makes, and the dollars received from their sale, takes a lively and whole-hearted interest in doing *his* job *better.* You can see this in the daily attitude of Sanborn employees. And, they aren't the only ones who profit from better instruments. You do, too, Doctor.

Descriptive literature on the Viso-Cardiette, and details of a 15-day no obligation clinical test plan will be sent on request. If you wish a copy of our Annual Report, we will gladly send you that also.

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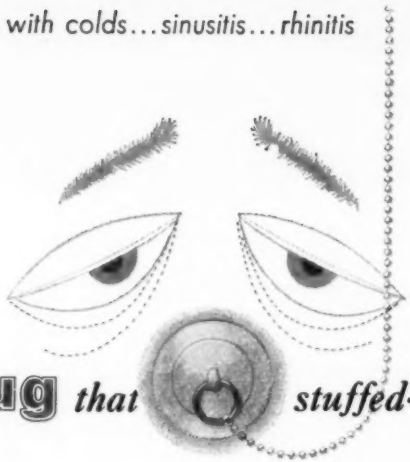

unplug *that* *stuffed-up nose*

orally *with*

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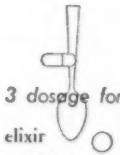
The marked synergistic action of a vasoconstrictor with an antihistaminic drug provides marked nasal decongestion and promotes normal sinus drainage. Oral dosage avoids harmful misuse of topical agents... eliminates nose drop rebound. Novahistine causes no jitters or cerebral stimulation.



3 dosage forms
elixir
tablets
fortis capsules

Each Novahistine Tablet or teaspoonful of Elixir, provides 5.0 mg. of phenylephrine HCl and 12.5 mg. prophenpyridamine maleate. Novahistine *Fortis* Capsules contain twice the amount of phenylephrine for those who need greater vasoconstriction.

PITMAN-MOORE COMPANY *Division of Allied Laboratories, Inc.*, Indianapolis 6, Indiana

Editorials

Malpractice threat stymies good medicine • What the credit men know about you • Met any 21-year-old surgeons? • Organizing the ideal committee

Medicine vs. Law

The country's top authority on malpractice, Dr. Louis J. Regan, wrote in our pages last month:

"There are physicians today who are *afraid* to use certain proved, useful diagnostic procedures. Why? Because there's one chance in a thousand that the procedure might harm a patient—and that one chance has resulted in a disproportionate number of malpractice suits . . . The public ought to realize that unwarranted malpractice claims make doctors hesitate to use scientific advances . . ."

Reading this, you may have wondered whether it was overstated. You may have said to yourself: "*I've* never hesitated to use the best procedure I knew, and I've never had a malpractice suit in my life. If I should have one—well, that's why I carry insurance. I can't believe that the malpractice menace would keep any doctor from doing what's best."

For such doubters, Dr. Regan has news: Some doctors on the West Coast *are* being kept from doing what's best. Here's how he describes one case that has inhibited them:

Dr. X was a cardiac surgeon. He was also a teacher of the diagnostic technique called aortography. Then one of his patients became paralyzed following an aortograph administered by a hospital resident under Dr. X's tutelage. The patient sued.

When the case reached court, events took a strange and disturbing turn. The judge, in his summation, *directed* the jury to apply the principle of *res ipsa loquitur* ("the thing speaks for itself"). Partly because of this guilty-unless-proved-innocent charge, the doctor and the hospital were held liable for malpractice.

Among the results were these: The patient was awarded damages of $250,000—the highest judgment ever in a medical case—and there was serious talk in medical circles that the teaching of such procedures might have to be abandoned.

"This ruling makes doctors hesitate to use their whole professional knowledge," says Dr. Regan. "I do not see how they can practice the best medicine under such conditions."

The procedure in question has made possible operations that have

1950	1952	1954	1955
Cortone®	Hydrocortone®	'Alflorone'	Deltra

restored substantial numbers of seriously ill patients to useful life. Yet today some medical men, according to Dr. Regan, are giving it up rather than run the risk of a malpractice judgment beyond their insurance.

When fear of malpractice action can thus block medical progress, it's time that the laws governing malpractice were changed. Otherwise patients will die *not* because they can't be saved, but because the law won't let them be saved.

Undermining Your Credit?

In these days of easy credit, no doctor thinks much about his credit rating. But plenty of other people do.

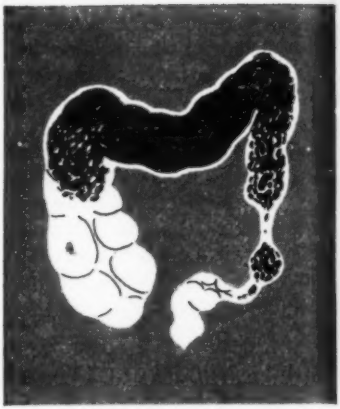
Your *personal* credit record probably got started when you were in medical school—or whenever it was you first had occasion to rent an apartment, open a charge account, or buy anything on time. This record, gradually accumulated, has been following you around ever since.

Some 1,750 credit investigating agencies throughout the country—all members of the Associated Credit Bureaus of America, Inc.—are constantly swapping reports. In thoroughness, tenacity, and access to confidential information sources about you, this credit network is a regular F.B.I.

Where do they get their information? Lots of places:

ANNOUNCING

THE FIRST NON-LAXATIVE TREATMENT OF CONSTIPATION



CONSTIPATION—DRY FECES

DOXINATE* | THE FECAL SOFTENER

• **Doxinate is** a wholly new type of therapeutic agent.

• **Doxinate acts** purely by physical means, solely on the intestinal contents.

• **Doxinate's only effect** is to permeate and homogenize hard fecal masses and thereby to restore soft, normal stools.

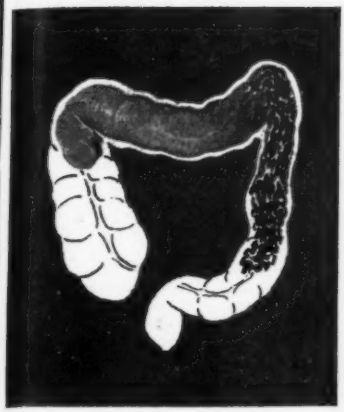
• **Doxinate does not cause** bowel movements — instead, it removes the primary cause of functional constipation (dryness) and permits normal elimination.

• **Doxinate is** unusually efficient and exceptionally easy to take. One small capsule, *once* daily, is sufficient to soften the fecal material.

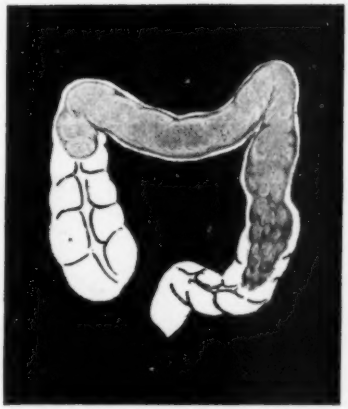
• **Doxinate is** safe and non-toxic because it is chemically inert.

• **Doxinate can be used** indefinitely, prophylactically or therapeutically, without fear of habituation.

• **You will find** Doxinate especially valuable in your pediatric, geriatric, surgical and obstetrical practice.



PENETRATION BY DOXINATE



RESULTANT SOFT, FORMED FECES

Doxinate is not oily and *does not leak* or interfere with vitamin assimilation or other digestive processes.

Doxinate does not irritate the bowel or cause "griping" or flatulence.

Doxinate is not a bulk producer. You can prescribe Doxinate without fear of its causing "bloat," "fullness" or impaction.

DOSAGE:
Adults, one or two capsules, once daily; for infants and small children, 1 cc. once daily in formula, milk or orange juice.

SUPPLIED:
Bottles of 30 and 100 capsules; each capsule contains 20 mg. specially purified dioctyl sodium sulfosuccinate. Bottles of 60 cc. with calibrated dropper; 1 cc. contains 10 mg. dioctyl sodium sulfosuccinate.

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BROTHERS, INC.
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High concentration

Topical Salicylate Therapy

for safer, more effective relief of rheumatic pain

High concentration topical salicylate-menthol therapy (BAUME BENGUÉ) offers safe, penetrating relief of painful joints and muscles caused by overexertion.

■ *Topical salicylate therapy is being rediscovered* as perhaps the safest, most effective remedy for aching joints and muscles.

Increased percutaneous absorption of salicylate, with enhanced blood flow through the affected tissue is provided by BAUME BENGUÉ, offering up to 2.5 times more methyl salicylate (19.7%) and menthol (14.4%) than other topical salicylate preparations. In arthritis, myositis, bursitis and arthralgia, BAUME BENGUÉ induces deep, active hyperemia and local analgesia.

Lange and Weiner suggest the term "hyperkinemics" to describe preparations such as BAUME BENGUÉ which produce blood flow *through a tissue area*. They point out that hyperkinemic effect, as measured by thermoneedles, may extend to a depth of 2.5 cm. below the surface of the skin. (J. Invest. Dermat. *12*:263, May, 1949.)

Two strengths: *regular* and *children's*.

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Baume Bengué

ANALGÉSIQUE

Menthol-induced hyperemia plus high local concentration of salicylate has been rediscovered as one of the most promptly effective remedies for rheumatoid discomfort due to exposure.

¶ From your bank, which describes your checking accounts in such phrases as "low four-figure balance," gives the size of any loans you've obtained, and tells how well you've paid them off.

¶ From your landlord, if you're a renter; he'll report the amount of your rent and how promptly you pay it.

¶ From your hospital, colleagues, neighbors, and patients; they supply a slant on your general character and enough information for an estimate of your income, an appraisal of your real estate and equipment, even a good guess at your collection ratio.

¶ From stores with which you do a charge business; they tell how long you've been trading with them, the size of the bills you run up, and how long it generally takes you to settle them.

Then there's your *professional* credit record. Among the agencies checking up on it is the American Surgical Trade Association. One recent edition of its "Credit Information on Physicians" lists specific payment lapses by more than 7,000 doctors. Even an uncollected bill for $2.39 dating back to 1923 is enough to get a physician's name in the book—and to keep it there through succeeding editions, until he settles up.

Some day in the future, you'll probably need credit in substantial amounts. How much you can get

will depend on what the credit agencies are reporting about you right now.

Wanted: Boy Wonder

Back in 1856, many an M.D. hung out his shingle at age 19 or 20. Nowadays a fully trained physician is often around 30. There's so much more to learn.

But at least one modern agency still believes in the boy wonder. According to a recent announcement from the Public Health Service, any youngster of "at least 21" can start right in as an Assistant Surgeon—provided he has seven years' "professional experience and appropriate training." In other words, provided he entered college at 14.

If he was really clever and started college at 11 (thus building up "at least ten years' training and experience"), he can begin as a *Senior* Assistant Surgeon with the Public Health Service. That's the equivalent of a captain in the Army.

Any boy wonders in *your* medical community?

Cues for Committeemen

How committees work has recently been studied by Harvard University's Laboratory of Social Relations. Its researchers set up a special observation chamber behind one-way

NOW—EFFECTIVE STEROID HORMONE THERAPY OF RHEUMATIC AFFECTIONS WITH GREATER SAFETY AND ECONOMY

PABALATE-HC

Robins

Pabalate with Hydrocortisone

Clinical evidence indicates that, in Pabalate-HC, the synergistic antirheumatoid effects of hydrocortisone, salicylate, para-aminobenzoate, and ascorbic acid achieve satisfactory remission of symptoms in *up to 85% of cases studied*

—*with a much higher degree of safety*

—*even when therapy is maintained for long periods*

—*at significant economy for the patient*

Each tablet of Pabalate-HC contains 2.5 mg. of hydrocortisone—50% more potent than cortisone, yet not more toxic.

FORMULA

In each tablet:

Hydrocortisone (alcohol)	2.5 mg.
Potassium salicylate	0.3 Gm.
Potassium para-aminobenzoate	0.3 Gm.
Ascorbic acid	50.0 mg.

DOSAGE: Two tablets four times daily. Additional information on request.

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widely prescribed because of these important advantages:

1) rapid diffusion and penetration
2) prompt control of infection
3) true broad-spectrum activity (proved effective against a wide variety of infections caused by Gram-positive and Gram-negative bacteria, rickettsiae, and certain viruses and protozoa)
4) negligible side effects
5) every gram produced in Lederle's *own* laboratories under rigid quality control, and offered *only* under the Lederle label
6) a *complete* line of dosage forms

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TETRAC
Attack
natural
by the
sealed
Also a
SUSPEN
LEDER

in prolonged illness, prescribe

ACHROMYCIN SF

TETRACYCLINE with STRESS FORMULA VITAMINS

Attacks the infection, bolsters the body's natural defense. Stress vitamin formula suggested by the National Research Council in *dry-filled, sealed* capsules with ACHROMYCIN, 250 mg. Also available: ACHROMYCIN SF ORAL SUSPENSION (Cherry Flavor), 125 mg. per 5 cc.

dry-filled sealed capsules

(a Lederle exclusive!) fo more rapid and complete absorption. No oils, no paste tamperproof!

LEDERLE LABORATORIES DIVISION *American Cyanamid company* PEARL RIVER, NEW YORK

Lederle

*REG. U.S. PAT. OFF.

XUM

glass. Then they watched unseen while committees of every sort held hundreds of meetings.

Any doctor who serves on a committee—and what doctor doesn't nowadays?—will find some useful ideas in the study group's conclusions. Take this common question: What size committee is most likely to get things done?

The Harvard researchers tested every odd size from three to fifteen members. Committees of three are too small, they found. Two members tend to align themselves against the third, who's likely to set up "a damaging but unsuccessful protest."

On the other hand, committees of nine or more are too big. In groups this large, "the low participators tend to stop talking" and a few strong men dominate the meeting.

Committees of five or seven men seem to be best. Big enough to permit free discussion, they're still small enough so that each member "has an adequate opportunity to communicate with each other member." Thus all share in the planning.

Of course, a committee needs good leadership as well as good size. Yet the chairman is seldom liked by his fellow members. By the very nature of his job, he must step on too many toes. He has usually lost his popularity by the second meeting, says the Harvard study group.

Then a "social leader" within the committee becomes the key man. He deals in personalities, leaving the unpopular selection of ideas to the

chairman. The important thing is "for these two men to recognize each other's roles and in effect to form a coalition."

Even when size and leadership are right, many committees take the wrong *approach* to their work. They start by looking for solutions instead of facts. A better approach, say the Harvard researchers, is this:

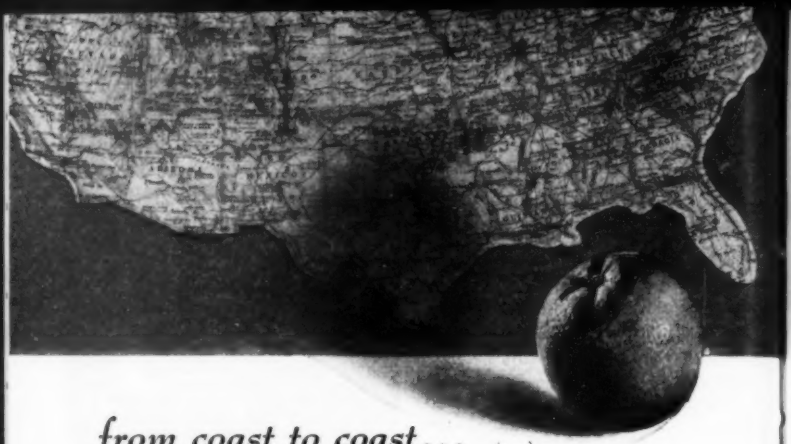
First the committee asks itself: "What are the facts pertaining to our problem?" Then it asks: "How do we, individually and collectively, feel about the facts?" Only when these two questions have been threshed out does the committee raise the final question: "How shall we solve our problem?"

If these ideas spread through hospitals and medical societies, doctors should find their committee work a lot less time-consuming—and a lot more productive.

Tax-Saving Tip

This month the Eighty-fourth Congress reconvenes. Well down on its agenda are the recommendations of the Hoover Commission. If enacted into law, these recommendations would save some *$7 billion a year* of the taxpayers' money.

But Congress isn't likely to do much without a push from the taxpayers. So if you didn't get a chance to speak to your Representative and your two Senators while they were home last fall, now's the time to write or wire. END



from coast to coast...

Adolescents need help to avoid vitamin C deficiency

Typical reports from nutritional surveys show:

Among 780 junior high school students in Maine, two-thirds of the boys and one-half of the girls eat diets deficient in vitamin C.[1]

Teen-age boys in Iowa neglect foods rich in vitamin C while girls stint on all foods to keep fashionably slim.[2]

Daily meals of students in four colleges of the Pacific Northwest provide inadequate vitamin C more than 60% of the time.[3]

The 'Citrus Snack' vs. 'Empty Calories'

The taste appeal of the 'citrus snack'[4] makes this a simple, satisfactory way to help compensate for the nutritional deficits of teen-age meals which are too often of "the hot-dog, soft-drink, candybar type."[6]

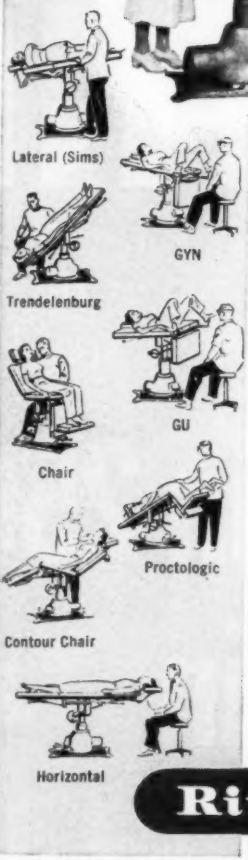
Teen-age Acne Problems may be a manifestation of inadequate vitamin C intake, and excellent results have been reported by correcting this deficit.[5]

Florida Citrus Commission
Lakeland, Florida

FLORIDA *Citrus*

ORANGES • GRAPEFRUIT • TANGERINES

1. Clayton, M. M.: Maine Agric. Exper. Sta. Bull. No. 495, 1951
2. Eppright, E., et al.: Fed. Proc. 11:442, 1952.
3. Fincke, M. L., et al.: J. Am. Dietet. A. 24:957, 1948.
4. Mack, P. B.: at Conference on Research in Medicine, Lakeland, Florida, 1954.
5. Morris, G. E.: Postgrad. Med. 14:443, 1953; Am. Pract. & Dig. Treat. 5:658, 1954; A.M.A. Arch. Derm. & Syph. 70:363, 1954.
6. Young, C. M., et al.: J. Am. Dietet. A. 27:289, 1951.



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PEDIATRICS BULLETIN

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

ACCIDENTS TO CHILDREN

AFTER the neonatal period, accidents lead all other causes of death in children. Accident-proneness on the basis of some psychological quirk has been emphasized as an etiologic factor but no practical program for prevention has resulted.

The possibility that undiscovered physical handicaps may underlie accident-proneness has been studied* on the basis of a questionnaire given to adults. Mentioned as examples were unilateral deafness, which prevents the accurate location of a source of sound; an unrecognized weakness from poliomyelitis to which the patient has not become adjusted; or temporary drug intoxication as from the antihistamines, sedatives, or atropine. This study did not particularly apply to children, but nevertheless, the basic concept is an interesting one.

It would be easy in the emergency of attending children after an acute accident, to miss certain obscure neurological or other physical handicaps which might have etiological significance. It certainly is wise to see the child again after the excitement of an acute injury is past, to review in detail the child's history and to repeat the physical examination. We may be too complacent in blaming an accident on childhood's heedless nature.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and appear periodically in Medical Economics.

*Gleason & Gleason: The New England Journal of Medicine, Vol. 253, No. 21, June 16, 1955, p. 1025.

Licensure: It's a Mess!

By Greer Williams

Thinking of taking up practice in another state? Your present license may become just a scrap of paper when you run afoul of the confused—and often completely unfair—medical licensure laws

● Remember the story of the bright young man who borrowed the name of a real Dr. Samuel P. Hall and practiced for seven years and in eight states before the F. B. I. caught him?

What imprisoned this phony physician was the felony of signing a government contract saying he was an M.D. It wasn't that he had practiced medicine without a license; that's a mere misdemeanor. And the really astonishing thing was that he had worked with doctors in twelve different offices, clinics, and hospitals without once being asked to present his license.

It's ironical that this public stamp of approval should be taken so lightly. But it is. As a matter of fact, an Ohio court not long ago ruled that a license entitled a doctor to nothing except immunity from prosecution for practicing without a license! [MORE ▶

THIS ARTICLE, *which describes the current shambles of medical practice acts in the U.S., is the first of three on the subject of licensure. In later articles, Mr. Williams will discuss possible reforms and will examine what seems to be the most likely solution in the long run.*

According to this theory, a license means little and ought to be easy to get. It seems to be just a wall decoration you need to make everything legal. You merely take an examination and pay from $10 (Alabama) to $100 (Nevada). In addition, you may have to pay from $1 (Florida and Virginia) to $50 (Virgin Islands) to renew your license each year.

Sounds simple, doesn't it?

Well, it isn't. Although you're licensed to practice in one state, you don't know what you'll run into in the next state, let alone ten states away.*

Reciprocity?

Connecticut, for example, will welcome a doctor with a New York license and will match it with one of its own. But New York will *not* honor a Connecticut license, though the latter's examining board is one of the best in the country.

Here's another example: Ohio will endorse or reciprocate the license of any state in the Union, including Florida. But Florida spurns the licenses of Ohio and of *every other jurisdiction.*

All that an additional license requires in many places is maybe a little waiting, some red tape, and a reciprocity or endorsement fee of $25 to $200. In others, you run into greater obstacles: You may have to take one or more examinations—and, in a few places, you may find yourself unable to pass, no matter how well you know the answers.

All this spells hardship for doctors, an estimated 100,000 of whom have found it necessary to practice across state lines or to move into another state during the last twenty years.

Neither doctors nor diseases change when they cross state lines. But the varying licensure laws may make you wonder, as some medical citizens have, whether America really is a free country.

A quick glance at some statistics will indicate the extent of the mixup. In 1954, 14 per cent of the additional licenses issued by the various states had to be obtained by examination; 66 per cent were issued by reciprocity or endorsement; and 20 per cent went to diplomates of the National Board of Medical Examiners.

The doctor who crosses a state line runs into two basic difficulties:

1. The laws change.
2. So do the medical boards that interpret the laws.

Basic Science Exams

The fact is, you hit a stumbling block in twenty-one states before you even get to the medical board. These states require you to pass an examination in the basic sciences. Any doctor a few years away from his pre-clinical training knows what a hardship that is. It has been ob-

*To be sure, forty-two states will exempt you from their licensure laws if you're called into the state for consultation. But if you maintain an office, home, or regular practice there, you'll need an additional license.

served that basic science laws have kept able doctors, even professors, out of some states where they've been offered appointments. They just haven't wanted to go to the trouble.

Such laws are often aimed at osteopaths. But the D.O.s have appeared quite happy to bone up on the basic sciences, in order to get a chance to practice medicine and surgery. So *they* commonly pass the basic science exam.

Lawmakers Lag

As for the medical practice acts, which lay down the licensing requirements—well, they're the most antiquated, mixed-up mess imaginable. Some of them were originally written fifty to a hundred years ago, before the development of modern transportation and communications. Designed to meet local needs and defend states' rights, they never envisioned the advance of science, education, and medical standards that has put a national-brand stamp on the American doctor.

The legislatures have often revised, amended, and patched their medical practice acts, to meet emergent situations and special demands. But the lawmakers haven't always worried about keeping up with the times. And they have been little concerned with whether their acts made sense in relation to those of other jurisdictions.

The A.M.A. made a survey, not long ago, of forty-nine licensing laws. In reporting the survey highlights, A.M.A. Attorney George E. Hall was forced to quote Little Abner to express himself. The facts, he said, were "amoozin' but confoozin'."

About all you can be sure of, it seems, is that you have to get a license to practice in *any* jurisdiction. And, before that, you've often got to pass some sort of examination.

The examination may be written, oral, or combined with some clinical demonstration of your knowledge. In some places, you may take it any time after applying. In others, at some given time each month. In still others, only after a three to six months' wait.

Waiting periods are *minor* inconveniences. But what about the content of the exams?

Boning Up

Let's assume you're an approved medical school graduate. You're already licensed somewhere. Perhaps you're even a diplomate of the National Board of Medical Examiners. Still, you can't be sure you will be examined in any subjects you've been examined in before—or even in what you were taught at medical school!

The forty-nine surveyed laws don't agree on a single examination subject. Not even surgery, though all jurisdictions license you as physician *and* surgeon. Forty-one jurisdictions will examine you in surgery; but eight skip it.

Or take obstetrics: Nine places as-

sume that as a physician you know something about delivering babies; but forty require a test.

Thirty-seven examine you in anatomy and physiology; twelve don't. Thirteen give you a pass on pathology, but thirty-six insist on examining you. Fifteen of the surveyed jurisdictions want you to know your legal medicine. One state tests your knowledge of its health regulations.

Thirty-one laws specify the examination subjects. But the other eighteen authorize the medical boards to add to the list.

In the long run, *everything* depends on the boards. And the boards are hardly predictable:

Some of them are bound to obey the letter of the law in the way they examine and license the physician. Others are given broad powers and can make their own rules. Only seventeen are required to make public reports of what they do. Some meet often; some seldom. A few are run by their secretaries.

Who *are* these people who presume to examine you?

By and large, board members are reasonable fellows who don't want to give you any trouble. Indeed, some are so accommodating that you may scarcely notice the absurdities of the laws they administer.

If you do run into obstacles—well, it's the law. A few boards operate under various stated or unstated policies of local partisanship, discrimination, or exclusion. This was all rather neatly captured in the remark of one state board secretary about another state board's policies:

"That state doesn't have a licensing examination, it has a valve. When the board members think they can let in a few more doctors, they open the valve. When they don't, they close it."

Naturally, as an outsider, you have no way of knowing whether the examination valve will be open or closed when you hit it. You may just "fail." Unless, of course, you have local influence.

Repeat Performance?

If you fail the first time, seven boards have the authority to decide whether you can try again or not. Thirteen boards will allow you only one repeat. Nine will take you back for further examination two or three times. About half have no restriction on the number of times you may retake the examination (in 1954, ten doctors got licenses after from seven to twenty-two failures in the jurisdiction of their choice).

Ten states don't specify any qualifications at all for the men who will examine you. One requires lay representation. Sixteen prohibit medical school professors from sitting on the board. About half provide that all board members be licensed, experienced, private practitioners.

In nineteen places, the Governor can appoint anyone he chooses to the board, without necessarily deferring to the medical profession. Customarily, however, [MORE ON 243]

Simple photocopier turns out

200 Itemized Statements In One Hour Flat

By Thomas Owens

● Signs are that many more doctors *want* to send out itemized monthly statements than actually *do*. The usual deterrent: Typing out detailed bills takes too much time.

"Naturally, I'd *prefer* to mail itemized statements," one physician told me recently. "I think they'd clear up any lingering doubts that patients might have about my charges. But we're so busy nowadays that my girl has barely enough time to type names, addresses, and amounts due on bills."

A novel solution to this problem has just recently become feasible for physicians. It's billing by photocopy. It does away with *all* typing at the end of the month.

Business concerns (and a few hospitals) have used this system for some time. But with the recent development of desk-top photocopy machines, that turn out dry copies in a matter of seconds, the idea now seems practical for small offices as well.

In addition to the diazo-type photocopy machine (cost: about $500), the system requires a set of master account cards made of heavy—but inexpensive—translucent paper. These include the doctor's letterhead, as well as all necessary explanatory material. Sample cards are shown on the two following pages. [MORE TEXT ON 104]

BURGAN, MRS. KATHERINE

MR. E. H. BURGAN
9242 CENTRAL AVE
INDIANAPOLIS 20, INDIANA.

BROADWAY 6669 Phone H-F New 3-1-55

THE INDIANAPOLIS CLINIC
2339 NORTH MERIDIAN STREET
INDIANAPOLIS 8, INDIANA

Please return this portion with your remittance WAlnut 3-2474

1 A. E. Blatt, M.D. 4 J. M. Leffel, M.D. 7 F. L. Toumey, M.D. 10 J. E. Mackey, M.D.
2 J. S. Browning, M.D. 5 I. J. Kwitny, M.D. 8 J. M. Young, M.D. 13 P. O. Eicher, M.D.
3 C. F. Gillespie, M.D. 6 I. W. Scott, M.D. 9 J. S. Schachter, M.D. 100 Laboratory
500 X-ray

Posting Date	Date of Service	Service	By	Folio	Debit	Credit	Balance
1955							
3- 1		OV	9	23456	5.00		
		LA	109		6.00		
		XR	500		7.00		20.00
3- 3		XR	500	24444	15.00		
		LA	109		3.00		38.00
3- 4		OV	3	25697	NO		
3-10		SU	3	28874	50.00		88.00
				3-11-55 BLUE SHIELD FORM TO PATIENT			
3-24		IR	3	30005		35.00	53.00
				PATIENT SAID WOULD PAY BALANCE 4-1-55			
4- 2			3	33370		15.00	
			9			5.00	
			109			11.00	
			500			22.00	-0-

Pay Last Amount

BA Basal Metabolism Study
CA Cast applied – removed
CB Cast bandage materials
CI Circumcision of Infant
CO Consultation
CR Credit allowed
CY Cytoscopic Examination
DC Deferred Charge
DE Diagnostic Evaluation
EC Excess Cash
EK Electrocardiogram
FE Included with other charges
HC Hospital Care
HV House Visit
IN Interview
IR Insurance Reimbursement
LA Laboratory Studies
MS Medication Supplied
MT Medication Treatment
MY Myelogram
NC No charge made
NS No Statement
OB Obstetrical Care
OR Orthopedic Evaluation
OL Outside Laboratory
OV Office Visit
SH Medication – Vaccinations
SS Special Service
SU Surgery
TR Transportation Allowance
UR Urological Examination
XR X-ray

THE INDIANAPOLIS CLINIC
Unless previously arranged, all accounts are due and payable by 10th of month.

GROUP CLINIC uses detailed account cards like this one. Patients get exact photocopies as their monthly statements. They can identify their charges by checking the code symbols against the key. In this clinic, charges are entered on the master account card by means of a bookkeeping machine.

STATEMENT

GEORGE A. BAXTER, M.D.
12 LINDEN ROAD
YORKTOWN, KANSAS
Dickens 7-0707

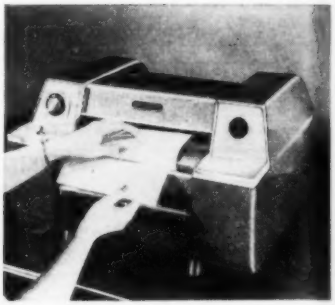
Mr. John P. Mason
12 Alexander Lane
Yorktown, Kansas

OV—OFFICE VISIT
CP—COMPLETE PHYSICAL
HC—HOUSE CALL
HV—HOSPITAL VISIT
SA—SURGICAL ASSIST
L—LABORATORY
A—ANESTHETIC
S—SURGERY
X—X-RAY

DATE	SERVICE	CHARGE	CREDIT	BALANCE
9-9-55	OV	$5.00		$5.00
9-23-55	CP	14.00		19.00
10-10-55	Cash		$19.00	-0-
10-28-55	L	7.00		7.00
11-7-55	S	150.00		157.00
12-10-55	Check		157.00	-0-
12-12-55	OV	5.00		5.00

SOLO PRACTITIONER uses simpler account cards. But photocopies provide his patients with all essential information about the doctor's charges. Note that entries on this account card are not typewritten, but are made in pen and ink instead. This means additional time-saving for the doctor's secretary. [MORE:▶

MASTER ACCOUNT CARD and light-sensitive paper are fed into the photocopy machine. Motor-driven rollers carry them inside to photo chamber.



SECONDS LATER, both sheets emerge. The aide removes the master card and, with her left hand, feeds the copy into a developer slot for processing.

Here's how the equipment is put to work:

After each service is rendered by the doctor, the aide marks down the appropriate charge on the patient's master account card. She also indicates the nature of the charge and the total amount due.

When billing time comes, the girl simply makes photographic copies of the master account cards. She feeds each card, together with a sheet of light-sensitive paper, into the photocopy machine (it can handle 300 cards an hour). When it ejects them, a few seconds later, all the data on the account card have been transferred to the second sheet of paper.

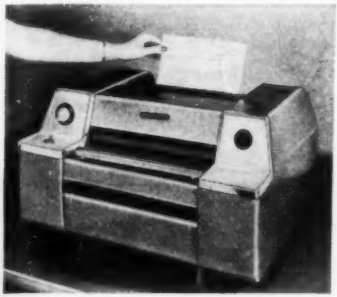
This, of course, becomes the patient's monthly statement. If it's mailed in a window envelope, the aide doesn't even have to address it.

Naturally, this procedure is a special boon to partnerships and group clinics, which prepare thousands of statements monthly. But many solo practitioners are also sold on it.

Take, for example, a Cincinnati OB man. He recently installed a desk-top photocopy machine. Although he sends out only about 200 statements a month, he and his secretary both say that the equipment is well worth its cost.

"I now get out 200 statements in one hour flat," the girl reports. "If I tried to type them, itemized as they are, it would take me a couple of days. And I'd still have to check every one for mistakes."

"Then, too," the doctor points out, "we find plenty of other work for the machine. My aide uses it to make



FLAT, DRY PHOTOCOPY is ejected at the top of the machine. It's ready for mailing as an itemized monthly statement. Elapsed time: 12 to 18 seconds.

copies of patients' histories for the hospital files, and of diet lists and instructions for patients. It's hard to estimate the amount of typing it saves—and the number of more important tasks my girl can do as a result."

How about patients' reactions? Do they object to getting a photocopy, instead of a bond-paper bill?

"We've heard no adverse comment," says the Cincinnati man. "After all, the photocopy doesn't look like a glossy snapshot. It has a perfectly flat finish, not at all unattractive."

The business manager of a medical group that recently installed a photocopy machine is even more enthusiastic. Says E. H. Burgan of the Indianapolis Clinic: "Without it, we used to be swamped with work at bill-mailing time. Since we average 3,500 patient visits a month, it was a back-breaking chore to get out itemized bills.

"It used to take the girls so long to type them that a number of the statements would be out of date by the time they were finished. So the girls would have to make about 250 changes (because of additional charges or payments) before the bills could be mailed.

"Now, with our photocopy machine, a single girl can get them all out in a couple of days."

There are other advantages, says Burgan. Because there are far fewer errors, the new system has improved patient relations. It has boosted the collections ratio. And since patients are now furnished with precise records of their medical expenses, they may stop flooding the clinic with calls just before income-tax time.

"The initial outlay of $500 for the machine sounds big," Burgan comments. "But there's no question in my mind that it pays for itself in one to four years." As for operating costs, here's what he reports:

The translucent master account cards can be bought for 2 cents each, including printing. The light-sensitive paper used for patients' statements costs half a cent a sheet. Developing fluid for 2,000 photocopies comes to 60 cents. And when you need to replace the machine's electric bulb (which ordinarily lasts a year), it will set you back about $35.

END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Ewing to Hobby to Folsom

This writer reports that medicine can hope for some unprecedented cooperation from the new Secretary of Health, Education, and Welfare

By Greer Williams

● What can doctors expect from Marion B. Folsom—Mrs. Oveta Culp Hobby's own choice to succeed herself as Secretary of Health, Education, and Welfare?

Recent history proves rather conclusively that it's best *not* to begin with great expectations:

Once upon a time, the A.M.A. dreamed that some day Congress would create the Cabinet post of Secretary of Health, and that the President would appoint a doctor of medicine to fill it. Then came the Truman Administration and the nightmare of Oscar Ewing—Mr. Welfare State himself.

Naturally, A.M.A. leaders opposed establishment of a department with Ewing at the head of it. But they went along with President Eisenhower when he called for—and quickly got—an act creating the new Department of Health, Education, and Welfare. And they hoped for the best from Secretary Hobby.

True, Mrs. Hobby, with her so-called "faucet charm,"

wasn't quite what the doctors had in mind. But they were led to believe that medicine would find an effective voice in her department through a Special Assistant for Health and Medical Affairs.

This man would, of course, be a physician.

Hobby's Choice

What happened has been summarized by Dr. Frank E. Wilson, director of the A.M.A.'s Washington office during that period:

"The A.M.A. nominated Harvey Stone as the first special assistant to Secretary Hobby. But she wouldn't take him. One of her objections was that he'd have to commute from Baltimore. So she picked Chester Keefer, who had to commute all the way from Boston."

Regrettably, in view of the department's other achievements, many physicians will remember the Hobby-Keefer era for the polio vaccine mess. (This was capped, you'll recall, by Mrs. Hobby's famous statement: "No one could have foreseen the public demand.") But. Dr. Louis H. Bauer, A.M.A. president in 1953, remembers the era for another reason:

'Advisory' Committee

"I had a pleasant talk with Mrs. Hobby," he recalls. "I asked her whether she'd like to have some doctors she could consult from time to time. 'I'd love it,' she said. I told her I'd submit a list of names, and she could appoint a committee from these nominees. 'No, *you* appoint them,' she said. So an advisory com-

Folsom on Social Security

Q. Mr. Secretary, do you believe doctors should be included in the compulsory social security program of Old Age and Survivors Insurance?

A. I have said for several years I believe O.A.S.I. coverage should be as nearly universal as possible. That is a good insurance principle and a desirable goal. So I would like to see coverage extended to cover each of the few remaining groups which are excluded now.

Q. How about doctors, more specifically?

A. If doctors choose to remain excluded from the system, I have some doubts whether they will be forced into it against their will. Congress has eliminated coverage of doctors from any Social Security legislation

mittee was appointed. It was never consulted by her!"

In sum, Mrs. Hobby proved so coldly, determinedly middle-of-the-road that neither right nor left side felt it was in touch with her.

The New Regime

Now comes Marion B. Folsom.

Soon, the President is scheduled to present his health, education, and welfare message to Congress. His proposals will undoubtedly be based on Mr. Folsom's recommendations. What, in the medical realm, are they likely to indicate for the legislative year ahead?

Will the new Secretary listen to the A.M.A.?

Will he push compulsory Social Security coverage for self-employed physicians?

What does he want in the way of health insurance for the nation?

During a recent interview with him, I had an excellent opportunity for a preliminary estimate of Mr. Folsom. He chatted freely and in a relaxed manner about his new job. And the general trend of his thinking became clear.

For one thing, he's definitely Social-Security-minded. Pointing out that coverage has already been extended to nine out of ten workers, he indicates plainly that he's after the tenth worker, too:

Compulsory Coverage

"Doctors, lawyers, and other professional people should come in," he has said. "Young doctors particularly need this protection for their families." [MORE ▶

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which has passed either house to date. I am hopeful that doctors will choose to come under the system as other groups have done. I think perhaps some doctors do not appreciate sufficiently the value of the survivorship protection, which can provide up to $200 monthly for a widow with two children. This should be especially desirable insurance for young doctors who need time to build up their earnings.

Q. Why do you favor compulsory rather than voluntary coverage?

A. The voluntary principle generally is unsound actuarially in the O.A.S.I program. It results in an adverse selection factor. That is, most of those who choose to come under the system may be expecting to retire soon. Thus they could draw full retirement benefits for a small investment. We must keep the system financially sound.

He would like to see *all* self-employed physicians covered compulsorily. He recognizes this as a sore point, however. And he's obviously eager to establish better relations with doctors than his predecessor had.

To this end, he has several times invited President Elmer Hess and other A.M.A. officers to his office and to lunch. A man who likes to debate opposing points of view, he has listened carefully to what they've told him.

His position on compulsory coverage is clear. It seems unlikely, though, that the Secretary himself will battle for compulsory coverage.

Folsom on Health Insurance

Q. Mr. Secretary, just to get the record straight, do you favor national compulsory health insurance?
A. This Administration is firmly against it.

Q. What are you doing about voluntary health insurance?
A. I am a strong believer in expanding and improving private insurance programs to provide the people with better protection against the costs of medical care and loss of income due to illness.

Q. In what particular fields are you seeking progress?
A. I think the first need is to continue some income for the worker through a sick-benefit plan. Two-thirds of the employed workers in some industrial states are already covered by such plans. They are compulsory in California, New Jersey, Rhode Island, and New York. I would like to see more states adopt similar plans.

Q. What new developments do you hope to see in insurance to meet the costs of medical care?
A. I believe one of the big opportunities for advancement lies in coverage of especially severe or prolonged illness, often called "catastrophic illness." Too many policies exhaust their benefits before major costs are met. This wipes out the savings of some families and forces some to turn to public assistance.

One medical observer familiar with Mr. Folsom's disposition expresses it in this sentence:

He Won't Fight

"The Secretary would be the last man to try ramming any kind of compulsory bolus down the doctors' throats."

In his interview with me, Folsom carefully avoided taking a position on H.R. 7225—a Democratic bill passed by the House in the last session and now awaiting Senate action. H.R. 7225 would bring compulsory Social Security to practically all self-employed individuals except physicians. What's more, it provides

---

Q. What can be done about this?

A. One of the best possibilities is extension of the principle of "deductible" insurance and co-insurance. That is, the individual provides through other means for meeting smaller, routine medical costs, but the "deductible" policy pays most of the major costs, at the higher levels up to $7,500 or $10,000. I believe this is a sound insurance principle, especially for group plans, and the premiums are surprisingly low.

Q. What other improvements are needed in health insurance?

A. Many older people find it difficult or impossible to get insurance now. I think it is a sound insurance principle to add a few cents to premiums in younger years and thus provide coverage for older people, including retired people. Also, there is a gap in coverage in rural areas, due to some extent to higher administrative costs. This gap, like some of the others, might be met by new types of policies to be worked out by insurance companies.

Q. So far you have talked only about private insurance activity. What about the Federal role? What about the reinsurance program advocated by the Administration?

A. I would like to see private insurance expanded and improved so it eventually protects the people just like life insurance does today. I think the role of the Federal Government is to do what it can, properly and soundly, to encourage this expansion and improvement. That is the purpose of the reinsurance proposal.

for widespread extensions of benefits and for gradual—but substantial—tax increases for all employers, employes, and self-employed.

'More and More'

The bill has been criticized as a typical manifestation of the political philosophy of "more and more." And Mr. Folsom himself has implied a private dislike for the bill. The reasons why may perhaps be found in a public speech:

"I believe the [Social Security] system is in pretty good shape today," he said recently. "We must always be careful that proposals for new benefits will preserve the essential justice and strength of the system. We must remember there is a limit to the Social Security taxes the people may be willing to pay."

Such a statement reflects the basic conservatism of Marion Folsom's point of view. It's the outcome of a long career as a businessman:

A Georgia storekeeper's son, a Phi Beta Kappa at 18, a Harvard business school graduate, he worked for one company—Eastman Kodak—for thirty-eight years, eighteen of them as its treasurer.

Though he began his career as a Southern Democrat, he eventually became a New York State Republican. He voted for Hoover in 1932. And he became Eisenhower's Under Secretary of the Treasury in 1953. As such, he played the key role in bringing about the first total revision of U.S. tax laws in seventy-nine years.

Thus, in training and experience, he's typical of the conservative breed who guard the money bags of business. At the same time, however, Folsom was inspired by the liberal George Eastman to become one of the nation's most welfare-minded businessmen. (Right-wing Republicans suspect him, indeed, of being a New Dealer in disguise.) He worked out the Kodak retirement plan in 1928; and by 1930 he had introduced a forerunner of the guaranteed annual wage.

At that time, he recalls, he was opposed to Federal Social Security and wanted to see industry take care of its own. "But the depression quickly changed my views," he says. "Private industry had all it could do to survive."

Roosevelt's Adviser

So Folsom proceeded to serve on the Roosevelt advisory council that helped draft the Social Security Act of 1935. And he acted as an adviser in later amendments expanding taxes, coverage, and benefits.

In short, though of penny-counting instincts, he's bullish about Social Security. He can be expected to push the system forward, but only as far as he thinks it economically sound to do so.

Recently he summed up his views in these words:

"I remember well the arguments made twenty years ago that the Social Security system would interfere with the individual's [MORE ON 252]

Your 1956 Tax Timetable: Nine Dates to Remember*

January 15 Pay the balance of your estimated Federal income tax for 1955—remembering that if this fourth installment doesn't make the total *paid* equal to at least 70 per cent of the tax actually *due*, you may have to file an amended estimate to avoid penalty. (In case you plan to file your *final* income tax return for 1955 on or before Jan. 31, omit this Jan. 15 installment.)

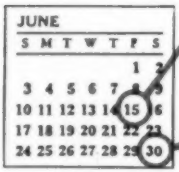
January 31 File Form 941 (including Schedule C) and pay amounts due. This form shows income taxes and Social Security taxes withheld from your employes' salaries. It must be accompanied by a separate Form W-2 for each of your employes. (And if you didn't pay your Jan. 15 installment of estimated income tax, you must now file your *final* income tax return for 1955 and pay the balance due.)

April 15 File your final income tax return for 1955, if you haven't done so already, and pay the balance due. File your declaration of estimated 1956 income tax and pay one-fourth the total estimated tax.

[MORE ▶

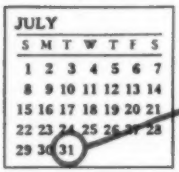
*Whenever the dates shown fall on Saturday or Sunday, tax returns are due on the next business day.

April 30 File Form 941 showing taxes withheld from your employes for the first quarter of 1956. Pay amounts due.



June 15 Pay second quarterly installment of your estimated 1956 income tax. Make sure that the sum of your first and second installments is equal to at least half your total estimated tax for the year. If necessary, file an amended declaration.

June 30 File renewal application for Federal narcotic tax stamp, together with inventory of narcotics presently on hand.



July 31 File Form 941 showing taxes withheld from your employes for the second quarter of 1956. Pay amounts due.

September 15 Pay third quarterly installment of your estimated 1956 income tax. Make sure that the sum of your first, second, and third installments is equal to at least three-quarters of your total estimated tax for the year. If necessary, file an amended declaration.

October 31 File Form 941 showing taxes withheld from your employes for the third quarter of 1956. Pay amounts due. END

Take a Letter, Doctor!

Take this one, for instance. It's from a girl with a sense of humor. It isn't meant for you, naturally. But if you were like her employer . . .

● Dear Doctor:

Last night after office hours, I sat panting at my desk and you stood there peering down at me through your bifocals.

"Doctor," I said, "I know this place isn't running as smoothly as those offices you see on television, but I don't honestly think it's all my fault."

"Whose fault do you think it is?" you asked.

Let me answer you, Doctor, by dragging out a bit of the past. The morning you interviewed me for this job, you said, "Never mind the fact that you've had no office

---

experience. Here's a little book that tells how to be Girl Friday to a busy doctor like myself. Anything you don't know will be in The Book."

Doctor, they don't make books that big. But Monday morning at 8 there I was—wide eyes shining with zest beneath a high, intelligent forehead; you in surgery; and only The Book between me and The Unknown!

While I was dusting, running sterilizers, and all that, you phoned from the hospital to tell me you'd be in at 10. Ten o'clock arrived, and you didn't. You came pelting in at 11—after Mrs. Bellows and her gall

"You came pelting in at 11."

bladder had marched out at 10:45, quite sure I had hidden you in the wardrobe closet.

The Book said promptness was one of the things you would insist upon. My promptness, Doctor? Not yours?

Mornings, while you were in surgery, I was supposed to type cards on surgery performed the day before. You had dutifully made notes, in your fine hand, on each operation; and by abbreviating and scribbling rapidly, you had no doubt saved a minute or two here and there. "Ac Ap" shortens "Acute Appendicitis" considerably. It also shortened my time schedule (for which you were paying me) considerably.

What with the phone ringing, patients pouring in, and your *very individual* handwriting, it seemed likely those first few days that I might create a new medical language—to say nothing of switching the human anatomy around a little. I referred to the "Medical Terms Made Easy" section of The Book; but obviously you never had.

When you arrived at the office the first morning, you praised my neat typing but said that the man's *pelvis*, not his penis, had contained 250 cc. of blood. I tried to explain that the phone had rung while I was typing the word. Whereupon you wanted to know if it had also rung when I translated "lac" in another case into "lacrimal" (which, you pointed out, did not seem at home in a dissertation on a lacerated cervix).

I then pointed out something on my own: The Book said I would always find you eager to make suggestions that would improve my work. Did you have any? Well, Doctor, you didn't look one bit

eager. Your only suggestion was that I should remember that "lac" always meant "laceration."

With your arrival from surgery, morning office hours began. The Book informed me firmly that when you buzzed from the examination room I was to make my little white legs fly. It said you would in all probability be waiting to do an examination that you couldn't do without me. So you buzzed.

At that moment, (1) I was on the phone, (2) a patient waited at my elbow, and (3) a young moppet was pulling the potted begonia out of the window. When I finally managed to fly to your side, you didn't say anything—but you didn't say it in a very nasty way.

"Yes, Doctor?" I asked.

Eyebrowing the patient, you said, "Put her up."

I said, "Up where?" And you looked extremely pained.

Eventually, we got it straightened out. But The Book had told me you'd say, clearly: "Please prepare Mrs. Goforth for pelvic examination."

However, you did demurely leave the room according to The Book. In fact, you clicked your heels out of there and showed me a backbone that I feared would never bend again.

I got Mrs. Goforth out of her girdle; I put her up in stirrups; I wormed her hips to the edge of the table; I rescued the pillow she had left behind; and I draped her (though, to tell you the truth, Doctor, I felt silly as I shyly draped the knees and left everything uncovered that *should* have been draped). Then I adjusted the light and got out the necessary supplies. I felt very efficient indeed.

"Put her up."

So I buzzed for you.

The Book said you'd be in the consulting room with the next patient. And it promised me that you'd come immediately, not leaving poor Mrs. Goforth in this awkward position a moment longer than necessary.

Remember where I found you? You were on the phone, talking to the Chairman of the Committee for the Betterment of Doctor-Patient Relations.

Doctor, before that day was over our patient relations suffered sc much that I felt positively ill.

Ah, illness! The Book said that if

I should fall ill, I would have no doctor bills to pay. Apparently that word "fall" is to be taken literally. As long as I remain in an upright position, you're obviously not going to take any better care of me than you do of yourself.

When I say, "Doctor, I have a pain right here," you laugh as if I've made a funny. True, one day you did flip down my lower eyelid to see if it were pale with anemia. But that redness wasn't good old hemoglobin, Doctor. It was due to loss of sleep while trying to make your books come out right.

And since I'm on the subject of balancing the books: Our little

"You twiddled five fingers at me."

manual said: "The doctor NEVER appropriates for his own use any cash that may have come in during the day, for this would disrupt the whole bookkeeping system. Instead, he writes himself a weekly check for cash, which is recorded in the log."

Well, I don't believe you know an office log from a hickory one. The very first day, I caught your long, surgically nimble fingers in the till—which is to say, that old dog-eared brown envelope in the top right-hand drawer. Doctor, why don't you skip lunches for a week and buy me one of those metal boxes?

Fees Set by Fingers

While we're so close to the subject of money: The Book says that as I learn to handle your collections, my salary will grow in proportion. Now this particular statement causes me to prick up my ears like a bird dog. But I've got to have some cooperation. Instead, here's what happened the other day:

You stood behind the patient and twiddled five fingers at me. I thought you were turning playful; so I collected only $3 for that $5 treatment you had given. Let's put such things down in black and white. If we don't, I'm going to wind up owing you money.

The Book says, very plainly: "When the last patient has gone, Doctor will summon you to his office. Take with you your stenographic notebook, pencil, appointment book, and phone numbers. Tactfully urge him to answer necessary mail."

Well, Doctor, that first day after the last patient had gone, I sat there

at my desk, clutching the mentioned equipment. After an interval of listening to the sound of paper rustling on your desk, I thought I heard you call me. Rising briskly, I hurried faithfully to your office—to find myself alone.

You had sneaked stealthily out the back door, knowing full well that I couldn't "tactfully urge" an empty chair.

The Book told me that in cases of this kind I might have to compose a few letters myself. "Don't," it said, "be afraid to show your style and originality." I stayed in the office until 6:30 that evening, showing my style and originality. The Book led me to believe that next morning *you* would do something to show your appreciation.

Next morning, you stalked into the office late; and, Doctor, your appreciation was not showing. In all fairness, I suppose it was dimmed by the two emergency operations you had done at 1 and 4 A.M. respectively. The Book said that in such cases I must remember that I was too well developed mentally to be merely a mirror to Doctor's moods. It said: "See how quickly you can make him mirror your own mood."

I tried to be gay. You hinted strongly that this was a physician's office, not a circus, and that I was no Emmett Kelly. So, first thing I knew, I was mirroring you in spite of my mental development; and pretty soon the patients were mirroring both of us. Mrs. Smythe wasn't herself because I pronounced her with an "i" and

"Make him mirror your own mood."

dropped her "e"; and Junior modestly demanded his penicillin in his skinny little arm instead of where it belonged.

By this time, of course, *you* were coming out of it. Whacking me heartily on the back (which helped no end in the preparation of 2 cc. of Vitamin B complex), you said: "Say, what's the matter with everybody around here?"

That night you sneaked out again, sans letter-answering.

So when you ask me now—a long time later—whose fault it is that our office doesn't run like clockwork, I guess there's only one answer: That little book you gave me—don't you think maybe you ought to read it too?

Sincerely,
Your Loyal Secretary

He Put His Industrial Practice on Wheels

In the course of providing medical examinations for industrial workers from Texas to Rhode Island, this M.D. has made a lot of friends, a few enemies—and some money, too

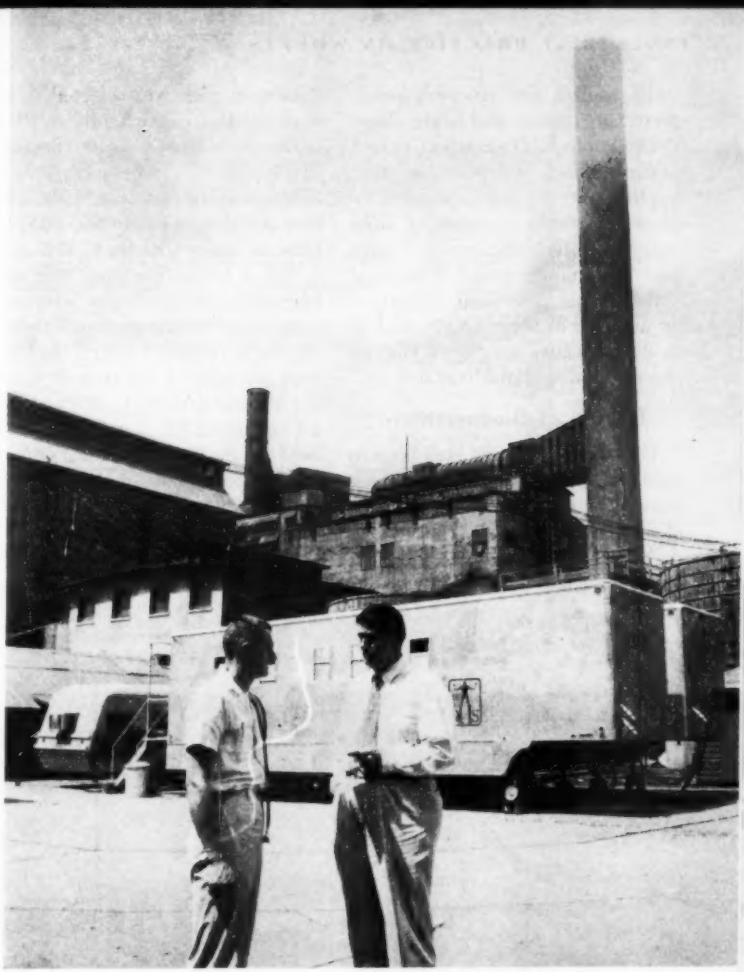
By John R. Lindsey

● Dr. Logan Thomson Robertson doesn't look like a highly mobile man. He's six feet five, weighs 250 pounds, and walks with a heavy step. Yet he covers more territory in a week than many medical men do in a year.

He's an industrial physician whose trade-mark is three aluminum trailers. With them, he's brought occupational medicine right up to the factory door in dozens of isolated plants from the Atlantic to the Rio Grande.

Logan Robertson is easy to talk to—but you have to catch him on the wing. When I first met him, last June, he'd just flown to Atlantic City from Asheville, N.C., where he lives with his wife and three children. Purpose of his flight: to read a paper entitled "Mobile Trailer Clinics for Periodic Examinations" before the A.M.A.'s section on preventive and industrial medicine.

Scarcely an hour after his arrival, we chatted in a taxicab that was rushing him back to his plane. "I'm on my way to Bridgeville, Pa.," he explained. "The General Electric plant there is starting a series of physical examinations aboard my trailers."



THREE TRAILERS of Dr. Logan T. Robertson's Occupational Health Services form a complete clinic that can be rolled up to the factory door. Here, outside the Champion Paper and Fibre Company plant in Canton, N.C., Dr. Robertson (right) is outlining to a colleague, Dr. John Britton, the procedures to be followed in examining 2,400 employes. Houselike trailer at left serves as a laboratory. The other two connect to form examining rooms. [MORE ▶

His trailers are air-conditioned, electrically heated, and worth about $50,000 apiece. On location, two of them interlock sidewise, so that employe-patients pass in planned sequence through a series of fully equipped, walnut-paneled, cork-tiled examining rooms. The third trailer carries a clinical laboratory for analyses of blood, urine, and so on. About fifty employes can be processed in an eight-hour day.

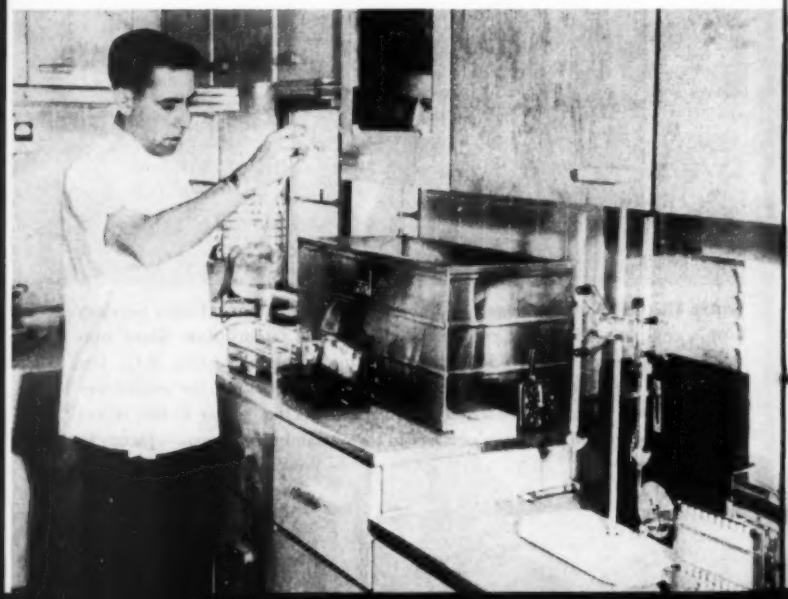
Family of Businessmen

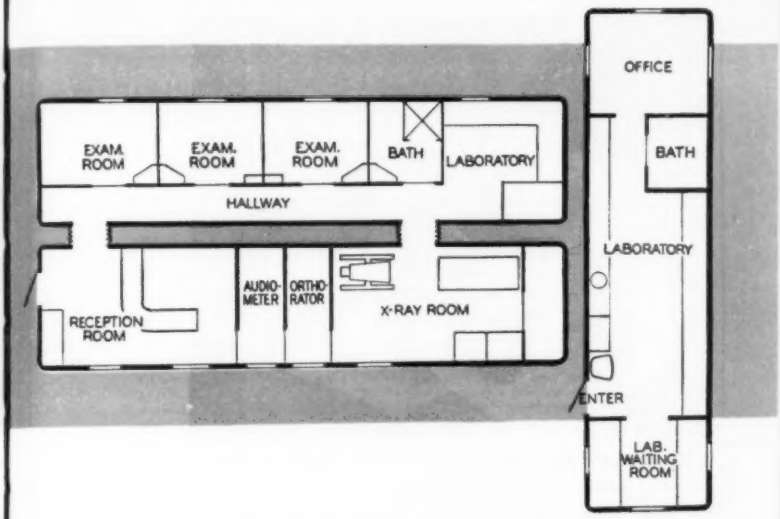
The doctor, now 39, was born to industry. His father, Reuben Buck Robertson, is chairman of the board of Champion Paper and Fibre Company and a past director of the National Association of Manufacturers. Robertson père was selected as industry's "Man of the South" in 1951.

Dr. Robertson's older brother, Reuben B. Jr., was president of Champion until early in 1955. He now serves as Deputy Secretary of Defense under Charles E. Wilson.

"It's a family tradition that only one son go into the family business," says Logan Robertson. "So I took up medicine, which I enjoy. But my background and interests have always been industrial. Since there's a tremendous job to be done in the field of industrial medicine, I've managed to combine my two favorite pursuits."

Following his graduation from the University of Cincinnati Medical School in 1942, he took up pri-





TRAIN-TYPE VESTIBULES—shown in this floor plan near each end of the hallway—join the two main 35′ x 8′ trailers of Occupational Health Services' mobile clinic. Factory employes receiving physical exams first enter the reception room (lower left). Then they cross through the vestibule into the adjoining trailer and pass through the examining rooms running along its entire length. Finally they cross back into the X-ray room and eventually leave the trailer by the same door they entered. Analyses of tests are made without delay in the third trailer (right).

UP-TO-DATE LABORATORY facilities are carried aboard the Occupational Health Services trailers. Urine, blood, and similar tests are completed in the lab-trailer while the employe-patient is getting X-ray, ECG, and other exams in the adjoining trailers. About fifty employes are screened every eight hours.

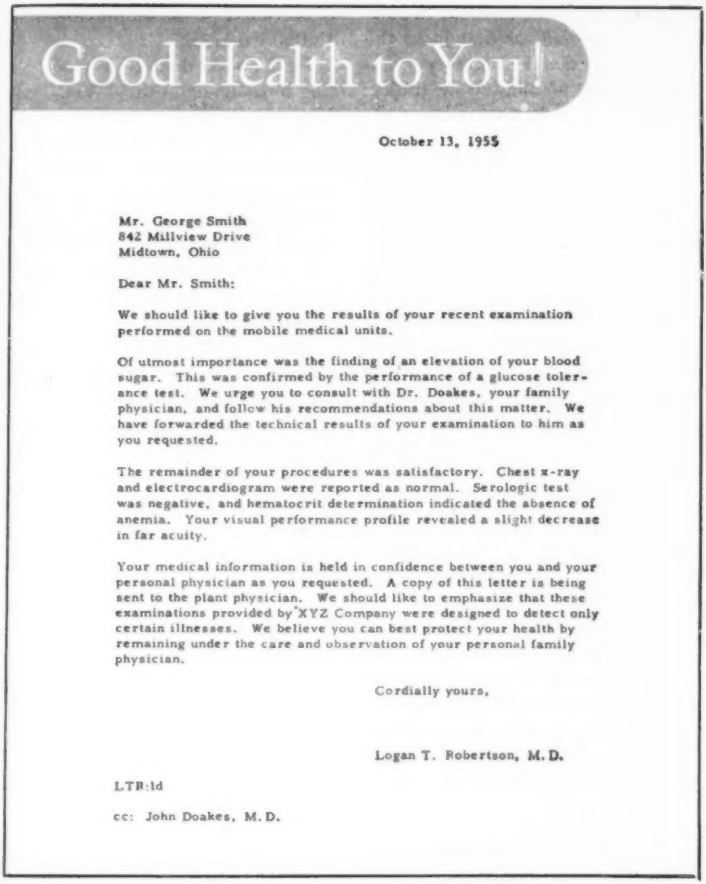
BUSINESS APPROACH of Occupational Health Services is reflected in the use of punch cards to record the medical history and examination results for each plant employe. Eighteen cards for each patient are keypunched to cover all phases of his examination. They're then used in cross-reference research studies. This scene is aboard one of the trailers.

vate practice in Asheville. He'd been a G.P. for six years before he put some of his occupational health theories to work.

"I'd been kicking around the idea of a trailer practice for a long time," he says. "Most of my friends are in industry. They kept talking about how much they needed first-rate care of the worker's health. They thought that only the big corporation could afford a really adequate medical program of its own.

"So I got to thinking about bloodmobiles. Why not, I wondered, equip trailers like a clinic and offer medical services to small companies that couldn't otherwise afford them? It seemed a practical idea, so I tried it out. And it works."

The name he gave this enterprise is Occupational Health Services. Through it, he offers industry the medical know-how and the clinical facilities for periodic (and in some cases pre-employment) examinations of a company's entire working force. His service is aimed at the



Good Health to You!

October 13, 1955

Mr. George Smith
842 Millview Drive
Midtown, Ohio

Dear Mr. Smith:

We should like to give you the results of your recent examination performed on the mobile medical units.

Of utmost importance was the finding of an elevation of your blood sugar. This was confirmed by the performance of a glucose tolerance test. We urge you to consult with Dr. Doakes, your family physician, and follow his recommendations about this matter. We have forwarded the technical results of your examination to him as you requested.

The remainder of your procedures was satisfactory. Chest x-ray and electrocardiogram were reported as normal. Serologic test was negative, and hematocrit determination indicated the absence of anemia. Your visual performance profile revealed a slight decrease in far acuity.

Your medical information is held in confidence between you and your personal physician as you requested. A copy of this letter is being sent to the plant physician. We should like to emphasize that these examinations provided by XYZ Company were designed to detect only certain illnesses. We believe you can best protect your health by remaining under the care and observation of your personal family physician.

Cordially yours,

Logan T. Robertson, M.D.

LTR:ld

cc: John Doakes, M.D.

ROBOTYPER PROCESS is used by Dr. Logan T. Robertson, medical director of Occupational Health Services, to turn out letters like this one to plant employes who've been examined in Robertson's trailer clinic. Detailed clinical reports—and a copy of the letter to the patient—are sent to each employe's own physician. Robotyper produces 150 individually typed letters a day in Dr. Robertson's Secretarial Division, Inc., one of his several business enterprises.

plant that has no medical department of its own, or that lacks the special clinical and laboratory equipment that the Robertson trailers carry.

Why It's Unique

His trailer idea, of course, isn't entirely new. A number of corporations, like the Phillips Petroleum and the Humble Oil and Refining companies, have used truck-powered clinics to reach their far-flung plants. One such company, for example, sends its mobile clinic to screen some 10,000 employes in 300 scattered field camps and sales offices. It takes four years to complete the circuit.

But Occupational Health Services seems unique in that it's owned and administered by an independent operator who's also a private physician.

It serves thirty small plants in North Carolina alone. But Dr. Robertson doesn't stop at serving small plants. He also serves big corporations whose employes are scattered in so many separate units that company medical programs are apt to be quite costly.

How It's Grown

Typical of the latter group is the family's Champion Paper company, which employs 10,000 mill workers in Texas, Ohio, North Carolina, and Georgia. Another big customer is the lamp division of General Electric, which operates forty-four widely scattered plants employing some 18,000 workers.

How does a doctor go about getting business like this? "Well," says Logan Robertson, "getting started in work of this kind is a bit like starting in private practice. But there's one big difference: You have to talk about your service to a lot of people. You have to find the right persons to talk to. And, on invitation, you have to explain in detail just what your service is."

Here's what a prospective client learns from Logan Robertson during any such discussion:

His trailers are staffed by a "cadre" of five: a registered nurse, three technicians, and a receptionist. Although Dr. Robertson is the medical director, he does none of the actual examinations himself.

Local M.D.s Examine

Who does them? Well, at first a salaried physician traveled with the trailers. But this raised the question of whether Occupational Health Services might be a corporation illegally practicing medicine. So today, Dr. Robertson finds his examining physicians locally.

At the Champion plant in Hamilton, Ohio, for example, Dr. Robertson works directly with the plant's medical director, who engages the medical men needed to examine some 3,200 employes. At the General Electric plant in Mattoon, Ill., M.D.s from a local clinic examine the 700 workers. But they always

use Dr. Robertson's trailer-truck facilities.

Occupational Health Services charges $20 for each full-scale examination. In addition, the company pays a flat rate of $2 a mile for the trailers' traveling expenses—one way only—from the last point of call. Dr. Robertson submits two separate bills: one for doctors' services, one for the trailer-clinic services.

Advance Planning

When a contract has been signed, a representative of O.H.S. goes ahead of the trailers, to work out an examination schedule with the company management. He also sets up a system of I.B.M. cards for recording the full results of every examination. "We use eighteen cards for each patient," says Dr. Robertson. "They cover all phases of his medical history and examination."

After the advance man has made preliminary arrangements, the doctor himself flies to the scene. Before the trailers arrive, he gives "orientation" talks to officers, supervisors, union leaders, and employes.

Makes Local Contacts

He also finds time to call on the local medical society. That's where he usually gets the names of doctors who might be interested in doing the examinations. And that's where he has occasionally had a cool welcome. For not all medical men are as happy about trailer-truck practice as Logan Robertson is.

In Youngstown, Ohio, for example, examination of G.E. employes aboard the Robertson trailers in the spring of 1955 touched off a debate that's still going on in the Mahoning County medical society.

Protest Shelved

While three Youngstown M.D.s were completing the trailer exams, some of their colleagues were proposing to discipline any doctors who cooperated in future operations of this kind. After hearing Dr. Robertson, however, the society decided to shelve the resolution, pending a report by a special investigating committee.

What were local doctors incensed about? In general, they complained that:

Their Complaints

1. O.H.S. offered workers no free choice of physician;

2. It interrupted normal patient-physician relationships; and

3. It might give employes a false sense of security in feeling they'd "passed" a complete physical exam.

Individual M.D.s raised other questions about O.H.S.: Were local doctors being exploited at $12.50 an hour, while the company had to pay $100 an hour? Had Dr. Robertson been ill advised in talking only to a few officers instead of "formally consulting" the society?"

Dr. Robertson believes such criticisms are based on "misunderstandings." He maintains that his service

benefits local physicians far more than it hurts them.

"How many workers voluntarily go to a doctor for physical examinations when they're feeling well?" he asks. "Probably fewer than 10 per cent. You might say we're taking away that small percentage of the local doctor's practice—but it's the local men who *do* the examinations.

"And of the 90 per cent of employes who wouldn't normally have a check-up, as many as half discover through O.H.S. that they've got physical defects needing attention. Such persons are referred to physicians of their own choice for treatment."

Like an Invasion

Still, resentment against Logan Robertson's service persists in a few areas. Houston, Tex., physicians continue to talk about what happened back in March, 1954, when the trailer-truck clinic rolled up to the doors of the Champion Paper plant in neighboring Pasadena.

Says one prominent Houston M.D.: "I resented the fact that the medical director came a thousand miles from his home area to furnish medical service to an industry, on the strength of his father being board chairman of the parent company. But I had no official basis for a complaint."

At the time, Dr. Robertson hadn't been licensed to practice in Texas (he's now licensed there and in Ohio and South Carolina, as well as in his home state). And the local medical society gave his trailers a frosty reception. For a while, it seemed likely that they might have to return to North Carolina without being used.

They Stuck It Out

"But we didn't turn tail," says the doctor. "Instead, the plant manager hired a Houston physician; and the physician himself hired the O.H.S. facilities. Then, with the help of other local M.D.s, he completed the screening of 3,000 Champion employes. The whole operation took about three months."

But the muttering among Houston doctors hasn't yet died away. "What is O.H.S., anyway?" asks one local man. "Has socialized medicine gone mobile?"

Dr. Robertson pours all his considerable strength into a denial of any such implication: "We're on wheels all right, but there's nothing socialistic about us," he says. "Just the opposite!

Needed by Industry

"We're doing a job that *industry* wants done. We provide medical examinations for the workers, and all the X-ray, ECG, and laboratory equipment needed to do them. Those would be pretty expensive items for an industrial plant to install. So we supply them for a per capita fee. We're free enterprise all the way!"

Logan Robertson's [MORE ON 250]

I'm a Doctor's Husband

Can life be beautiful when a layman marries a G.P. in skirts? It can—but also plenty hectic

By Nathan C. Fuller

● My wife left me last night. Not once but twice. What's more, she was an hour late for lunch today; and this evening she waltzed out just as dinner was being put on the table.

What kind of flighty girl did I marry? An irresponsible adolescent? A social butterfly?

Neither. I married a doctor. And my doctor-wife isn't a pediatrician or a gynecologist, like most reasonably sane women physicians. She's a G.P. [MORE ▶

You, reading this, are a doctor—probably a married one. So you may think you've heard every possible complaint that a physician's spouse can make about the bad hours you keep and the scant attention you pay your family. But a spouse like me can come up with a few *special* gripes.

Let me tell you about them—and about how I got myself into this fix:

Outsider and Broke

I'm a life insurance agent in Rockland, Me., a town of about 10,000. My wife moved here six years ago and set herself up in general practice. She was broke; she was a woman; and she was an outsider. But even so, she managed to get along fine.

She built a solid practice in relatively short order, averaging about 100 deliveries a year. Until recently, when an internist came to town, she did most of the electrocardiograms for other doctors and hospitals in the area; she also did minor surgery and assisted in major surgery. All this, of course, in addition to the usual rigors of small-town general practice.

Somehow, too, she found time to meet and marry me. And we've lived happily ever since—though not exactly in storybook fashion.

No Hours for G.P.s

It isn't just because she's a *doctor* that we haven't followed the customary script. It's chiefly because she's a G.P. I know that most specialists can regulate their professional hours and integrate them with a family life. But I now know, too, that a woman can't be a little bit in general practice, any more than she can be a little bit pregnant.

My wife *is*—in general practice, I mean. And she responds to calls at any hour. Since the arrival of our son two years ago, she has curtailed her obstetrical practice somewhat. But she has made no other concessions to family life.

Are you wondering how a full-time distaff G.P. can also be a mother? Well, it's not easy; but Dr. Fuller somehow manages the job—with a little assistance from Mr. Fuller, I might add.

Nursery Specialist

By the time our son was a week old, I knew how to fold a fine diaper and brew a bottle. How could I help it? Baby's cries always seemed to be timed with emergency calls for the doctor of the house. Lacking a medical degree, I've had to specialize in nursery impedimenta.

Still, I suppose our boy will develop a general-practice psychosis well before puberty. His first spoken sentence was, "Mama's on a hou' call." From earliest infancy, he's accompanied his mother on quick trips to the hospital when no one was available to baby-sit. Once when I was out of town on a short business trip, his mother even had to cart him around the neighborhood on a whole series of night calls.

I had reason to suspect I was in for an unusual married life even before the baby arrived. The diagnostic rabbit had scarcely reacted to the needle when strangers began stopping me on the street to inquire about my pregnant doctor-wife. And hardly had the baby been delivered when there was talk—much of it to my face—that Dr. Fuller was enceinte again.

Since such gossip can affect a doctor's practice, if he's a she, we Fullers were on the spot. We had to devote ourselves assiduously to spiking rumors about the precipitous growth of our family.

Worse still was what happened last winter, when I was hospitalized out of state for a couple of weeks. It was nothing very serious; but it gave currency to a choice story: I had gone away for a vasectomy, people said, because my wife was pregnant

HE CAN COOK, TOO: Mr. Fuller feeds dinner to son Timothy, 2, while his G.P. wife is away on a house call. "Thank God, I married a man who has all the natural attributes of a good pediatrician," says Dr. Barbara Fuller.

again and we didn't want any more children.

I hadn't. She wasn't. We do.

Children or no children, the married life of an insurance agent (male) and a G.P. (female) is an intricate affair. Our household routine is more complex than Vitamin B. In addition to our son, a French poodle, and two cats, our home contains two separate offices and six telephones. To keep this menage operating, we must maintain a payroll of four.

There's a sitter who takes care of the baby three evenings a week and on Saturday afternoons, during the doctor's office hours. There's a five-day-a-week housekeeper, a two-day-a-week cleaning woman, a full-time secretary for the doctor, and an answering service for the six telephones.

Cured and Insured

Since we both have our offices at home, it has been suggested that we hang out a sign: "She Cures 'em; He

Inside the Doctor's Pockets

Women doctors are apparently just like other women: They've got to have some place to store their bobby pins and Kleenex. But they don't carry handbags, only the standard doctor's bag. So what do they do? Well, judging by this incidental intelligence from Nathan Fuller, they learn to make spectacular use of their pockets.

● I was hunting for the car keys the other day, and I finally looked in my wife's trench coat. This is a roomy garment (once mine) with four extra-big pockets outside, and two more inside.

I didn't find the car keys, but I did find the following items:

Upper Left Pocket. Two apples; three milkweed pods (to be dried); one safety pin; one sample bottle of vitamin pills; three pieces of paper with names and addresses on them; one small wad of Kleenex.

Upper Right Pocket. One stethoscope; four sample tubes of medicinal jelly; two gas receipts (August and October, 1955); one apple; the upper half of a fountain pen.

Insures 'em." But we've resisted that temptation, just as we've resisted the temptation to take each other's calls.

Not that I don't occasionally answer the telephone for Dr. Fuller. Usually, someone at the other end launches into some such tale of woe as this: "My daughter has broken out all over with spots. What shall I do?"

In such cases, I—like a doctor's wife—listen sympathetically. When I can break in, I explain that Dr. Fuller will call back as soon as possible. But the mere fact that I listen to the complaint sometimes seems to have a perceptible therapeutic effect.

Jelly Sale

In the same vein, I'm sometimes a fairly adequate stand-in for my wife when a detail man turns up. Just the other day, I listened to a brisk discourse on the virtues of a new vaginal jelly. I tried, in turn, to sell *him* an insurance policy. But it was no sale—either way. [MORE ▶

Lower Left Pocket. Two pieces of tourniquet tubing; one large wad of Kleenex; one crumpled envelope, unopened (it later proved to be an announcement of a meeting last May); one large collection of bobby pins, loose; one diaper, used for wiping off windshield; one sterile metal tube, with syringe; one handkerchief; male (mine).

Lower Right Pocket. Three pieces of fudge, wrapped in foil; six small bottles of saccharine tablets; one prescription pad, tattered; one small roll sterile (?) gauze; three nickels; one pigskin glove; seven safety pins, assorted sizes.

Inner Left Pocket. Empty. Either being saved for reserve storage, or else inconvenient for my wife to use (she's left-handed).

Inner Right Pocket. One small silk scarf; two more sterile metal tubes, with syringes; one $5 bill, crumpled (Internal Revenue Service, please ignore); one tape measure, cloth; two small medicine bottles, filled but unlabeled; one more collection of name-and-address notes, all sizes and degrees of legibility.

° ° °

Incidentally, I later located the car keys in the bathroom.

No matter how carefully we plan our lives, bedtime and mealtime are real gambles. We always regard it as a red-letter night when there are no phone calls, no house calls, no deliveries.

Deaf to Phones

I'm so conditioned to night phone calls now that I scarcely hear them. Usually, when my wife goes out, I have to be roused and told to tune my ears in for baby cries. But I don't rouse easily.

I remember one morning when I arose and tried to awaken my wife. She didn't want to get up. I chided her: Hadn't she had more than a full night's sleep?

I was wrong. She'd gone to the hospital at midnight, delivered a baby, and returned to bed about 4 A.M. without my knowing anything about it.

Mealtime has its crises, too. We usually prepare dinner together; or my wife starts it and I finish cooking while she goes off on a call. I've learned to eat without waiting for her to return.

Once in a while, though, the doctor has to wait for *me*. We use our two cars interchangeably; and I remember the evening I went out to sell a few insurance policies. Frantic phone calls chased me around town. Seems Dr. Fuller had left her medical bag in the car *I* was driving—and she had an urgent house call to make.

The life we lead hardly permits us to be the social lions of Rockland. Of course, we do go to parties—especially to those given by doctors and their wives. But such events aren't necessarily happy ones.

Usually, the guests divide into a male group and a female group rather early in the evening. Then what do we do? Should Dr. Fuller join the other doctors, or should she join their wives? Should I join the nonmedical sorority to discuss the servant problem, or should I butt in on the boys talking shop?

Generally, we make the split according to sex rather than occupation. So Dr. Fuller listens to wife-and-mother chitchat, while wistfully eying the medical huddle across the room. And I, in the middle of a heated conversation on hospital staff tenure, try to switch the talk onto civic affairs or hunting.

He Guards His Tongue

But I'm careful what I say about doctors, because I'm in the curious position of having a foot in each of two camps. When a fellow layman complains to me about physicians in general, I either defend the profession or keep my mouth shut. I avoid asking friends how they feel, since they'll *tell* you how they feel, when you're married to a doctor. And I never recommend my wife to any potential patient. She's too busy as it is.

I'm not completely lost when the topic is medicine. I won't maintain that I've acquired a [MORE ON 248]

Legislation to Watch

Here are the highlights of eight legislative proposals now pending in Congress. Any one of them, if enacted, could have a profound effect on you as a physician. Use the following chart to brief yourself on their contents and prospects

SUBJECT: Federal disability benefits.
BILLS: S. 2094, H.R. 7225.
SPONSORS: Sen. Potter (R., Mich.), Rep. Cooper (D., Tenn.).
PROPOSALS: Permit permanently disabled workers to draw at age 50 the Social Security benefits they would normally draw at age 65.
COST: $50 million to $100 million annually, to be paid through higher Social Security taxes.
PROSPECTS: Fair. Labor groups strongly for it, medical groups strongly against. Administration wavering in the middle.

SUBJECT: Health insurance for Federal workers.
BILL: S. 2425.
SPONSORS: Sen. Johnston (D., S.C.), Sen. Carlson (R., Kan.).
PROPOSALS: Permit Federal civilian employes to arrange payroll deductions for approved voluntary health insurance. Let them choose from among local plans, regional plans, and a national indemnity plan. Let them pay their own way, assisted by Federal contributions up to $52 per employe per year.
COST: $50 million to $100 million annually in Federal funds.
PROSPECTS: Good. No important opposition to the basic idea. Some opposition to the national indemnity plan. Compromise likely to bring health insurance to 2 million Federal workers, 3 million dependents.

SUBJECT: Federal aid to medical schools.

BILLS: S. 1323, H.R. 4743, H.R. 3297 et al.

SPONSORS: Sen. Hill (D., Ala.), Rep. Priest (D., Tenn.), Rep. Burnside (D., W.Va.) et al.

PROPOSALS: Provide one-time Federal grants to medical schools covering up to two-thirds of their new construction and modernization costs.

COST: $250 million in Federal funds over a five-year period.

PROSPECTS: Fair to good. A.M.A. has endorsed these bills. No important group opposes them. But Administration wants to fit them into a master plan for general-education grants.

SUBJECT: Tax deferment for the self-employed.

BILLS: H.R. 9, H.R. 10, H.R. 2092 et al.

SPONSORS: Rep. Jenkins (R., Ohio), Rep. Keogh (D., N.Y.), Rep. Ray (R., N.Y.) et al.

PROPOSALS: Permit the self-employed to put as much as $5,000 a year into privately managed retirement funds, up to a total of $100,000—such funds to be exempt from income tax until drawn out after retirement.

COST: No direct Federal cost. Indirect tax loss estimated at $1 billion annually.

PROSPECTS: Good. Professional groups strongly in favor. Administration supports it, too, but may make plan part of a package with compulsory Social Security for the self-employed.

[MORE ▶

SUBJECT: Federal reinsurance of voluntary health plans.
BILLS: S. 886, H.R. 3458, H.R. 3720 et al.
SPONSORS: Sen. Smith (R., N.J.), Rep. Priest (D., Tenn.), Rep. Wolverton (R., N.J.) et al.
PROPOSALS: Reinsure voluntary health plans against abnormal financial losses while they experiment with broader coverage.
COST: $25 million to $100 million in Federal subsidies—this fund to be replenished by health plans using the service.
PROSPECTS: Poor. Administration still nominally for it. Not many other important groups.

SUBJECT: Medical care for military dependents.
BILLS: S. 2720, H.R. 7792, H.R. 7806.
SPONSORS: Sen. Russell (D., Ga.), Sen. Saltonstall (R., Mass.), Rep. Price (D., Ill.).
PROPOSALS: Guarantee dependent care to servicemen's immediate families. Permit Government payment of private physicians, civilian hospitals, and voluntary health plans, when authorized by the Secretary of Defense.
COST: $75 million to $100 million annually in Federal funds.
PROSPECTS: Fair to good. A.M.A. sought bigger role for private physicians, succeeded in getting it. Defense Department is pushing hard in behalf of 2 million military dependents.

SUBJECT: National compulsory health insurance.

BILL: H.R. 95.

SPONSOR: Rep. Dingell (D., Mich.).

PROPOSALS: Provide tax-financed, Government-controlled health insurance for everyone under the Social Security system.

COST: $5 billion to $10 billion annually, to be paid in part by higher Social Security taxes.

PROSPECTS: Almost none at present. But the plan is dormant —not dead, like Dingell.

SUBJECT: Social Security for physicians.

BILLS: H.R. 5031, H.R. 6049, H.R. 6811 et al.

SPONSORS: Rep. Anfuso (D., N.Y.), Rep. Kean (R., N.J.), Rep. Johnson (D., Wis.) et al.

PROPOSALS: Extend Social Security to physicians, dentists, lawyers, and others now excluded.

COST: No Federal estimate available. The self-employed would pay 3 per cent tax annually on their first $4,200 of net income.

PROSPECTS: Fair. Administration supports the idea but isn't pushing it. A.M.A. strenuously opposes compulsory coverage of physicians. END

The Doctor as

What does he do when he steps out for a social evening? How much do his professional duties get in the way? Here are enlightening answers

● A Midwestern G.P. attended a large cocktail party not long ago. Soon after he arrived, a young matron, glass in hand, elbowed her way through his circle of friends.

"Doctor," she said, "can you tell me what might be causing recurrent pains in my left side? They've been bothering me for several days."

It was a cartoon situation come to life—and the doctor

as a Social Animal

[THE PRIVATE LIFE of the U.S. physician—his health, his family, his personal habits, his social life, his community service, his politics, his recreation—is now being examined by MEDICAL ECONOMICS in a series of nation-wide polls. Upwards of 1,200 questions, divided into categories, are being asked of samples of male physicians in private practice. Each physician is given only one category of questions, but a total of 15,000 will be queried in all. This is the fourth article based on their replies.—ED.]

reacted accordingly. As the woman moved her free hand over her satin-swathed abdomen, he said to her: "Sure, just slip off your gown, and we'll have a look."

"You mean *here?*" she quavered.

"Where else?" said the physician crisply. "My office isn't open till tomorrow."

Off duty, the typical doctor likes to think of himself as

a normal social animal. His main complaint is that people won't let him be one.

What kind of social life *does* he lead, then? And how much effect does the fact that he's a doctor have on his after-hours activities? For answers, let's look at the results of MEDICAL ECONOMICS' recent survey of several thousand American M.D.s:

The Doctor's Night Out

The typical doctor clearly doesn't qualify as a playboy. By his own report, he goes out for an evening with friends just twice a month. And he dresses for formal affairs only twice a year, not counting professional meetings.

Plainly, too, he's a family man. He takes his wife and children out to dinner about three times a month. And he accepts two-thirds of the invitations he gets mainly to please his wife.

Says a Maine surgeon: "It's worth a little torture to give my wife an evening away from the children."

Only 3 per cent of the social gatherings that the surveyed doctors attend are stag. And on a typical night out, fewer than 2 per cent of the men will be found in nightclubs or bars. Fully 70 per cent will be sedately whooping it up in private homes, and another 20 per cent in private clubs, hotels, or restaurants. The rest will be scattered among church socials, theatres, card parties, and bowling alleys.

Today's doctor apparently steps out at a measured pace. Barely 14

per cent of his invitations are for cocktails. Half of them are to dinner parties; and 10 per cent of the time he's asked to drop in *after* dinner.

When he attends an after-dinner party, he'd rather talk than dance. Nearly two-thirds of his social life, by his own report, is spent in conversation. Only 7 per cent is spent in dancing. But nearly every physician surveyed admits he *can* dance ("if I have to"). Some comments:

¶ "I dance only under duress."

¶ "I'm too fat."

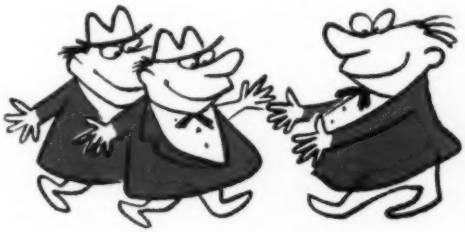
¶ "I dance only when I've had a few drinks."

What's his favorite dance step when he does indulge? As you might expect, the fox trot and waltz run one-two, with the rhumba a very poor third. Square dancing, samba, mambo, tango, and polka follow in that order.

How does he spend New Year's Eve?

A year ago the typical doctor stayed home or went to a party at a friend's house.

The Doctor Entertains



The typical doctor entertains, on the average, twice a month. On the last three occasions, he had company for cocktails once, for dinner once, and after dinner once. But he also seems to like week-end or overnight visitors: About 15 per cent of his guests, he says, are of this type.

He keeps his entertaining informal, no matter what form it takes. Fewer than 13 per cent of the qualified respondents say their daughters will have (or already have had) a formal debut.

In an informal atmosphere, talk is the number one staple of entertainment at the doctor's house. It has a 2-to-1 lead over other forms of social activity—with cards, television, dancing, and other games next in order.

Of all parlor games, his favorite is bridge (first choice of 40 per cent of the physicians surveyed). Poker is preferred by 23 per cent. Next come

chess (8 per cent), canasta (5 per cent), and pinochle (4 per cent).

Among what groups does the doctor find his social companions? As you'd guess, the best friends of the surveyed men are other physicians: Fifty per cent of the average M.D.'s guest list is made up of doctors and their wives.

Still, the physicians polled count among their "five closest friends" men in 150 different occupations. Among the more unusual companions: a steam fitter; a prize fighter; a racing-car designer; an antivivisectionist.

One physician confesses that one of his best friends is a chiropractor. ("But only my *fifth* best friend," he adds.) And a Seattle proctologist writes: "I've never seen one of my close friends—a taxicab driver 3,000 miles away in Pennsylvania. But we've been playing chess together for years, by mail. I know few men in this world half as well."

A composite list of the doctor's "closest" friends would include, in this general order: business executives, lawyers, dentists, salesmen, engineers, farmers, insurance men, pharmacists, teachers, bankers, accountants, brokers, clergymen.

But the typical M.D. lists five physicians to every businessman or member of another profession.

The average respondent sends Christmas cards to about 100 persons, exclusive of patients. A few men report mailing 400 or more. One says he sends 500 "personal cards," plus 2,500 to patients.

He's Still a Doctor

How often does the typical doctor have to turn down an invitation because of his practice? How often must he leave a party to make a call? The apparent answer to both these questions: some 10 per cent of the time.

Surprisingly, about a third of all

respondents say they rarely have to break an engagement or rush away from a social gathering for professional reasons.

As one Illinois G.P. explains it: "My patients understand my hours and respect them."

In contrast, a Southerner moans: "Seems like I always have to leave 'em after I get there. So now I don't like to go at all."

Emergency Calls

Sometimes, of course, the physician encounters an emergency at the party itself.

"Half a dozen couples were playing bridge," recalls a Texas dermatologist. "Suddenly the hostess collapsed.

"We moved her to a couch, and soon thereafter I delivered her of a seven-pound girl in plain view of ten witnesses. It was my first delivery in ten years."

Another bridge party provided even more work for a Missouri general practitioner. The story, as he tells it, goes like this:

Triple Trouble

"In the midst of the first rubber, the phone rang. The child of one of the guests had swallowed perfume. The parents rushed me over to their home for an emergency medical treatment.

"No sooner was I back at the party than the phone rang again. Another sick child. Another couple. Another mad dash in their automobile. Another emergency medical treatment.

"I'd returned to the card table for only thirty minutes when one of the guests went into labor. As soon as I could wash my hands, I delivered her of a boy. And she wasn't even one of my patients!"

Socially speaking, few laymen run the occupational risks a doctor regularly faces in public. Here are some reportedly true experiences of confused doctor-patient relationships at social gatherings, as derived from MEDICAL ECONOMICS' latest survey:

Her Last Chance

¶ A New Mexico G.P.—we'll call him Dr. Francis—says his ears burned at a party recently, when he overheard the following loud remark: "I wonder whether Dr. Francis can get me pregnant. None of the other doctors in this town have been able to."

¶ "What happened to me," says a New York State man, "could have happened to anybody with a strong arm and high spirits: I was dancing with a lively, middle-aged matron, and I fractured her rib. Being a doctor helped in repairing the damage and squaring the bill. But it made my embarrassment considerably more acute."

¶ Writes a New Jersey physician: "To liven up a recent country club dance, the hosts for the occasion had handed out variously colored tags, and the guests were supposed to ex-

change partners by matching up colors. When I found my partner—a handsome woman I was sure I'd never seen before—she exclaimed: 'I *would* have to draw *you* as a partner!' It dawned on me then that I'd examined her proctologically for a colleague just the month before."

He Has to Talk Shop

Public enemy number one at all social functions, from the doctor's point of view, is the layman who wants to talk medicine. Nearly 50 per cent of the surveyed men mention this as the thing that disturbs them most at parties.

The layman, it seems, insists on bringing up anything from an analysis of his own ills ("organ recital") to the latest clinical paper in the Journal A.M.A. In between, he too often wants to discuss the doctor's fees, his practice, and his income.

So, whether he wants to or not, the medical man talks shop. The survey reveals that medicine—including medical economics—has a 4-to-1 lead over its nearest rival (sports) as a topic of conversation at the parties doctors attend.

The physicians say they aren't happy about it. What's more, many of them aren't happy about the amount of shop talk that goes on even among themselves. Forty-five per cent of the respondents complain that doctors in general talk about medicine more than they should.

What do doctors think about mixing practice and pleasure in their social life? Here are some typical comments:

¶ "It's O.K. if not overdone. But some eager beavers think only of getting more business."

¶ "I can't relax at social gatherings where there are patients. I have to watch too closely what I say and do."

¶ "As a coincidence, it's fine if your friends consult you profession-

ally. But if you plan it, it's lousy."

This last comment, from an Alabama G.P., apparently sums up the majority view of practice-building in the drawing room. The average doctor reports that out of ten typical social engagements, two eventually bring him new patients.

His Pleasures and Pains

"What's wrong with your social life?" the doctors were asked. And some straightforward answers came in. Among them: "There's too much of it" . . . "Doesn't include enough people outside the profession" . . . "I'm too tired to enjoy it."

"I feel it's too often a continuation of my work," complains one medical man. "Where there are people, there are inevitably problems."

Nevertheless, of all doctors polled, 28 per cent say they'd be more active socially if they could. Only 6 per cent would prefer to be less active. The rest are quite content.

But though the average medical man seems fairly satisfied with his social life, he isn't keen about *everything* that goes on at parties. Besides the pet peeve of lay medical talk, 15 per cent of the respondents say they hate gossip; 13 per cent complain about too much drinking; 8 per cent dread the late hours.

Says one man: "The false friendliness gets me down." Says another: "It's no fun being constantly on guard against any act or deed affecting your reputation."

Another respondent speaks for many when he says: "I most dislike other doctors' patients asking about the kind of care they're getting."

What does the doctor like *most* about social gatherings?

First, talking with his friends. Next, what he calls "relaxation." Third, meeting new people—especially, as one respondent puts it, "intelligent lay people who talk about anything but medicine." END

THE GREAT FLUORIDATION FRACAS

By Hugh C. Sherwood

The battle may soon take place in your community, if it hasn't already. Want to win it? Here's how you can profit from the rugged experiences of doctors elsewhere

• Fluoridation is on the march. Many communities already have it; many others have voted it down. If the question hasn't yet arisen in your town, chances are that it soon will. And when it does, you can expect to be caught up in a rough-and-tumble fight.

If you and your medical colleagues know what to do, you can easily win friends for medicine. If not, you may lose both the fight for fluoridation and a good measure of public confidence.

Within ten years, says Dr. A. P. Black of the University of Florida, "fluoridation of public water supplies will be as routine as chlorination." But today, only about a thousand American communities drink fluoridated water. And in communities that have voted on the question, fluoridation has lost more often than it has won.

It has lost despite the support of the A.M.A., the American Dental Association, and the Public Health Service. It has lost although most of the opposition comes from food faddists, professional crusaders, chiropractors, and their ilk.

The opposition, you see, knows how to wage this kind of warfare. It organizes. It expends huge quantities of time, money, and enthusiasm. It accuses its opponents of sympathizing with communism or world government, of wanting to pour rat poison into communal waters.

Actually, as most doctors know, the addition of one part of sodium fluoride to every million parts of water is a promising preventive against tooth decay. Extensive tests have shown that it's tasteless, cheap, and safe.

Why, then, have so many towns and cities voted against it? The typical experience of Cincinnati provides one answer:

In 1952, the Cincinnati City Council approved a local fluoridation program. In 1953, the city's waterworks superintendent announced that the program would begin within a month. By then it had been widely publicized, had been given full public hearings, and had received the backing of Cincinnati's physicians and dentists.

Less than three weeks after the announcement, however, a well-known local radio commentator moved into the act. He cited a magazine article that emphasized possible dangers in fluoridation. Although the article had been denounced by the A.D.A. as misleading, the commentator shrugged off such expert opinion. Instead, broadcasting four times a day, he began to make increasingly violent attacks on the program.

Soon, letters were pouring into City Hall. Sample quotes:

"The water already tastes and smells bad" . . . "Isn't it enough that we have to drink the rotten, filthy sewage you're already dishing up?" . . . "Fluoridation will harden the eyeballs, arteries, and many other parts."

Meanwhile, the anti-fluoridationists marshaled their

SCARE CAMPAIGN follows most efforts to introduce fluoridation to American communities. Its opponents often label it a "Red plot" or "chemical warfare." These slogans have been disturbingly effective in scaring older voters.

forces. They flooded the city with propaganda. They accused the doctors of a secret conspiracy. And they presented their own "experts" to give "the other side," thus implying there was a split in medical ranks.

'A Poison Plot'

Some reputable medical men believe, of course, that the safety of fluoridation hasn't been conclusively proved. A few others feel that, as mass medication, it smacks of socialized medicine. But the anti-fluoridation forces in Cincinnati didn't limit themselves to such arguments. They charged that the projected program was "a poison plot" or a "Communist scheme."

As a result, they forced a new public hearing before the City Council. Eventually, they demanded—and got—a public referendum. And in the end they won: Cincinnati voted against fluoridation by a 7-to-5 margin.

Doctors Blamed

The program was voted down, says one well-informed observer, because medical organizations failed to get the facts before the public. And this failure, he maintains, stemmed from shortsightedness: The fluoridationists hadn't anticipated a fight. And so they couldn't understand the nature of the fray once they were in it.

A similar story unrolled last year in Monroe, Wis. (pop. 7,000). Little public education preceded the proposal to introduce fluoridation there. And when a physician spoke out for the program at a P.T.A. meeting, opponents introduced a chiropractor from a neighboring town as *their* "expert."

Townspeople quickly assumed that the fight was between two medical factions. Then the anti-fluoridationists struck while the iron was hot. They filled the mails with poison-pen cards. They conducted door-to-door campaigns. They gave radio addresses and street-corner speeches.

Monroe Was Scared

The anti-fluoridationists were organized—and they had national backing. (Two of three officers of their "local" committee didn't even live in Monroe.) They had wads of literature, which "proved," among other things, that fluoridation speeds up cancerous growth and is a method of Red warfare.

As in Cincinnati, backers of fluoridation organized too late. They spent much of their time investigating and refuting fantastic charges, instead of selling their own program. And they found that the anti-fluoridationists had managed to pressure the courage out of much of the Monroe populace.

Local businessmen said they couldn't actively support fluoridation for fear of losing customers. Pleas for places to display pro-fluoridation posters were turned down. Feeling ran so high that a number

of doctor-patient relationships were seriously disturbed.

When it came to a vote, fluoridation lost in Monroe by a 2-to-1 margin.

Now let's look at a different story. Let's see how another community *won* its battle for fluoridation by blunting the crackpots' weapons:

Two years ago, the Junior Chamber of Commerce of Palo Alto, Calif., began a drive for fluoridation. At first it limited its efforts to telling the public what fluoridation was, what it would do, and what it would not do. But the chamber also got ready for open war.

It set up a downtown headquarters. It set aside a small sum to finance the campaign. Finally, it lined up the support of dozens of business and civic groups.

A steering committee met weekly to direct the fluoridationists. It organized the city into precincts. It sent women out on doorbell-ringing campaigns; and it saw to it that automobile bumper strips were passed around.

In Palo Alto, the opposition to fluoridation was led by a religious-book and health-food salesman. Its principal activity was a letter-to-the-editor campaign, which successfully confused many voters.

But fluoridation's supporters sen-

"I don't think young Zackley there is going to make it."

it's a rare child* who doesn't

(and he's taking

PARKE, DAVIS & COMPANY · DETROIT, MICHIGAN

sntake to

or

sibly paid little attention to such activities. Instead, they hammered home the theme: "The merchants of fear send their salesmen to Palo Alto—but we don't scare easily!" This turned out to be a most effective slogan, since anti-fluoridationists had been compelled to import help from San Diego and Seattle.

The fluoridationists also built their campaign around two other ideas:

Advertising Paid Off

1. Voters were urged to ask their physicians and dentists for "the facts about fluoridation." (The community's professional men unanimously backed the program.)

2. Voters were told via repeated advertisements: "This is the time to be known by the company you keep." (More than 1,000 community leaders signed the ads.)

Why Palo Alto Won

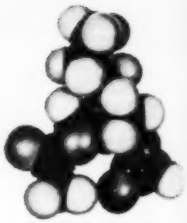
When the votes were counted, fluoridation had won, 7,500 to 6,000. By educating first, then organizing, then conducting a carefully planned fight along political (*not* scientific) lines, Palo Alto got what Cincinnati and Monroe had lost.

"Education of the public takes a long time," says Dr. Frank C. Stiles, who was prominent in Monroe's losing fight. "We've learned that such education can't be carried out during the heat of a political campaign."

[MORE ▶

Two articles in the April 30th issue of
The Journal of the AMA[1,2] *report on . . .*

an entirely new type of tranquilizer with muscle relaxant action— orally effective in



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LITERATURE AND SAMPLES AVAILABLE ON REQUEST

When can it be carried out? Right now, perhaps, in your town. But it takes community-wide organization.

In San Francisco, for example, the fluoridation forces included business and civic organizations, racial and ethnic societies, the P.T.A., the League of Women Voters, and other groups. A local labor leader acted as chairman. And this community-wide combine eventually won.

Once opposition arises—well, that's when the shooting starts. Many doctors prefer to stay out of it. But a good number of them find that they can't.

For such men, Dr. Stiles has this hard-won advice:

Know Your Enemy

¶ Make sure you've read the opposition's literature and know what it says.

¶ Be ready to grapple with scare questions like: "Doctor, does fluoridation cause cancer?"

¶ Know who the opposition's so-called "authorities" are. (One of the best-known "experts" escaped from a mental institution; another has been convicted of fraudulent advertising.) For help in learning their backgrounds, you can query the A.D.A.

¶ Talk with townspeople about fluoridation in *their* language. (One Cincinnati newspaper suggested, only half-humorously, that many local residents thought "dental caries" meant a group of female dentists named "Carrie.") END

Don't Settle for Less Than a 9% Return

By Martin Kimberly

Even if you're in a modest tax bracket, your invested savings ought to yield at least 9 per cent (dividends plus appreciation) just to preserve their purchasing power. Here's how—and how not—to arrange it

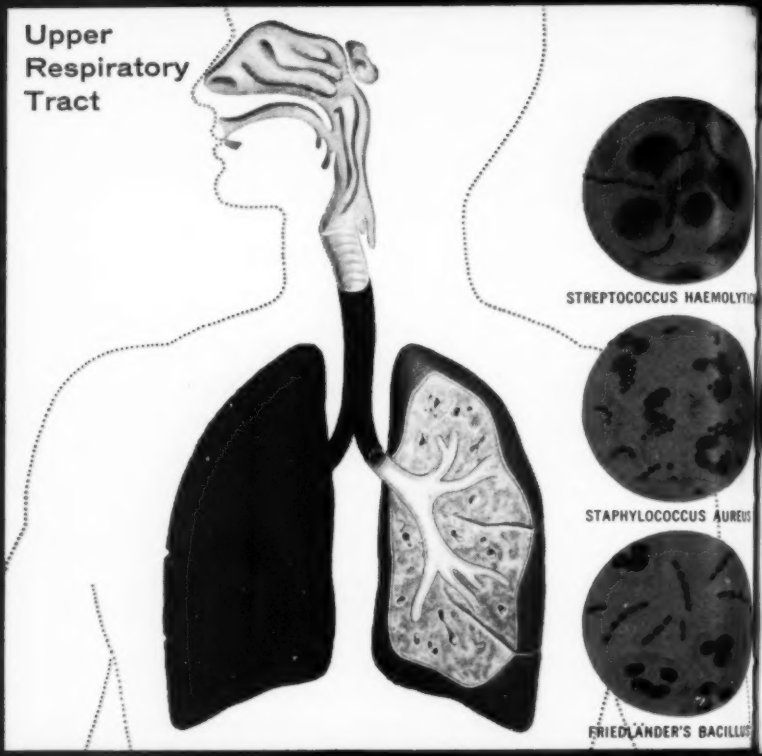
● In our investing, as in other activities, it pays to sit back once in a while and take a good look at where we're going. It pays to ask ourselves: What, exactly, should be the physician's investment aim?

I've done a good deal of thinking about this. And it seems to me the answer is simple: Our ultimate objective should be to preserve—if possible, to increase—the purchasing power of our savings.

Just look at the record: An item that cost $1 in 1939 probably costs $2 today. By 1964 the same item will most likely cost at least $2.50. That's a 150 per cent price rise in just twenty-five years.

To preserve purchasing power in the face of such inflation, invested money must yield a net return of 6 per cent. Note that I said *net*. An investment has to gross a lot more than 6 per cent to net 6 per cent. [MORE ▶

"MARTIN KIMBERLY" is the pen name of a practicing physician. This article has been adapted from a portion of his book, "The Fundamentals of Successful Stock Market Investing," The William-Frederick Press, New York, 1955.



FOR MULTIPLE ATTACK

Infections of the upper respiratory or lower urinary tract are commonly associated with mixed bacterial pathogens. Combination therapy is the logical approach.[1,2]

BICILLIN-SULFAS provides multiple attack through two distinct antibacterial mechanisms. These actions give the physician the means to achieve control over a wide range of mixed infections,

TABLETS

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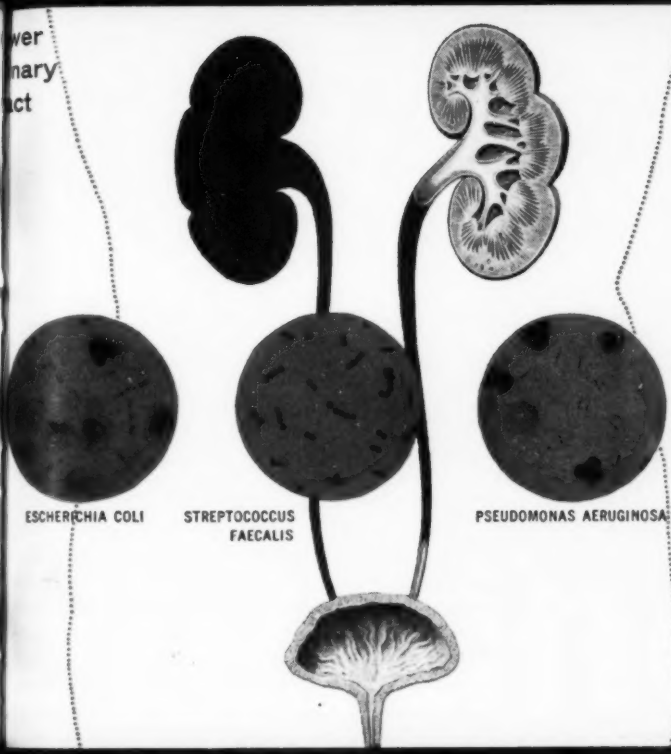

ON MIXED INFECTIONS

both gram-positive and gram-negative. BICILLIN-SULFAS combines BICILLIN, the penicillin with a surety factor for absorption, and SULFOSE®, the highly soluble triple sulfonamide of low renal risk. For oral therapy distinguished by maximal safety and effective blood levels.

1. Daly, J.W.: Antibiot. & Chemo. *4*:687 (June) 1954. 2. Spink, W.W.: J.A.M.A. *152*:585 (June 13) 1953.

SUSPENSION

SULFAS

Dipenicillin G) and Triple Sulfonamides

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NINE PER CENT RETURN

For one thing, there are commission charges to be paid. If you buy a security with a money value of $100, the commission is about 6 per cent ($6). If the value of the security is $500, you pay 2 per cent ($10); if $1,000, 1½ per cent ($15).

For another thing, there are taxes. If you're in a 25 per cent income tax bracket, you must get an 8 per cent dividend in order to wind up with a dividend that will net you 6 per cent. If you're in the 60 per cent tax bracket, and if a security yields only 5 per cent, you keep only 2 per cent.

Figuring Percentages

So it boils down to this: To net the 6 per cent needed merely to *retain* purchasing power, a man in the 60 per cent tax bracket must gross more than 15 per cent a year on his investments; the man in the 25 per cent bracket must gross about 9 per cent. The extra percentages in each case are siphoned off by taxes and commissions.

Investors in the 60 per cent tax bracket often turn to tax-free securities—for example, the tax-free bonds floated by municipalities and states for public works projects, schools, roads, etc. But such investors aren't in the majority. So we'll direct most of our attention to the man in the 25 per cent tax bracket—the man whose aim is to find securities that will give him an annual return of 9 per cent or better.

How to do this?

Let's begin by noting what the

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*brand of prednisolone

main types of securities have to offer. Take a look, first, at so-called *income securities.*

Income Securities

These are the kind that return a steady yield and exhibit a relative lack of variation in price. People buy these securities for their safety.

Income securities may take the form of Government bonds, corporation bonds, preferred stock, or common stock. Government savings bonds return about 3 per cent per year. Good-grade corporation bonds return from 2½ to 4 per cent a year at issued value. Good-grade preferred stocks return from 4 to 6 per cent.

A number of common stocks have achieved enough stature to be considered good-grade income securities. American Telephone & Telegraph is the prime example. Year in and year out, it pays $9 a share. But this doesn't mean 9 per cent, because the stock was recently quoted at 186¼, at which point the yield was of course only about 4.8 per cent.

None of the good income securities, then, returns the desired 9 per cent. So we must look further into other types of investments.

Growth Stocks

Consider the securities known as *growth stocks.* In these, about equal weight is given to safety of principal and to opportunity for capital appreciation.

What, exactly, is a growth stock? It's the stock of a company that shows

THORAZINE* *can allay the suffering*

caused by the pain of SEVERE BURSITIS

The ataractic, tranquilizing action of 'Thorazine' can reduce the anguish and suffering associated with bursitis. 'Thorazine' acts not by eliminating the pain, but by altering the patient's reaction—enabling her to view her pain with a "serene detachment" . . . Howell and his associates[1] reported: "Several of [our patients] expressed the feeling that ['Thorazine'] put a curtain between them and their pain, so that whilst they were aware that the pain existed, they were not upset by it."

Smith, Kline & French Laboratories, Philadelphia

1. Howell, T.H.; Harth, J.A.P., and Dietrich, M.: Practitioner *173*:172.
*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

a more rapid growth than comparable companies show over a long period.

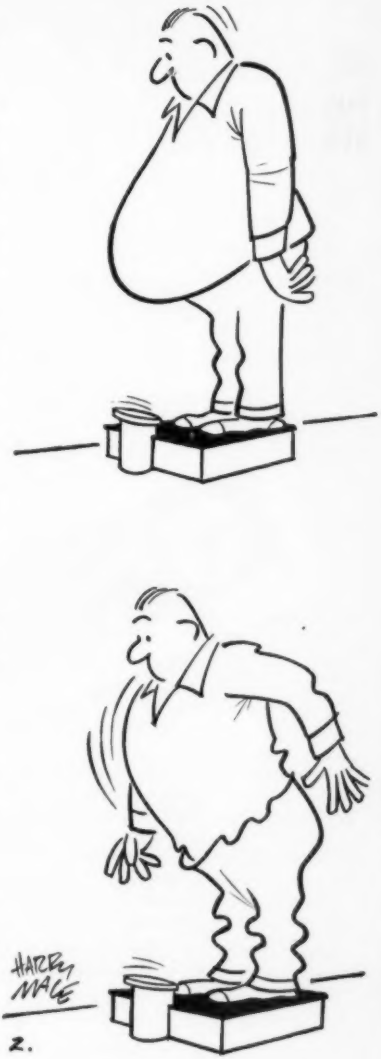
Growth corporations usually put a large percentage of their earnings back into research and expansion, rather than distribute these earnings as dividends. When this reinvestment policy pays off, the stockholders profit because of the higher market value of their stock—not because of the dividends received.

To show what a big difference this can make in your ultimate profits, let's compare two hypothetical companies. We'll assume that each company has the same number of stockholders (five million) and the same number of shares outstanding (also five million). We'll also assume that each company shows an annual profit (after taxes) of $1 per share from 1948 through 1951.

Let's say Company A pays out most of its earnings in dividends, while Company B retains a big slice of earnings for research and expansion.

Here's how these differing reinvestment policies affect the stockholders of each company:

Company A in 1948 pays out $4½ million in dividends (90 cents a share) and retains a half-million dollars to reinvest in the business. During 1949, 1950, and 1951, it does exactly the same. Thus, by 1952, the company has reinvested $2 million of its earnings. As a result, the company is now selling more and better products; so its earnings are up. In



1952, the company earns $1.11 a share and pays out a $1-a-share dividend.

What does this mean to the stockholder? In 1948, Company A's stock sold at $18 a share. With a 90-cent dividend, it was thus yielding 5 per cent.

In 1952, it sells at $20 a share. And with its new $1 dividend, it still yields a 5 per cent return.

Now let's figure in capital appreciation. Suppose an investor had bought ten shares of Company A's stock in 1948 for $180. Then suppose he'd sold them in 1952. He'd have made $66 on an investment of $180—a gain of about 37 per cent in five years.

That's a gain of about 7½ per cent a year, of which 5 per cent is dividend gain and 2½ per cent is capital appreciation.

As you can see, that's still short of the 9 per cent required to maintain purchasing power for a man in the 25 per cent income tax bracket.

Company B, a growth company, has the same earning history as Company A. But its earnings are allocated differently. In 1948 the company pays out only $2 million in dividends (40 cents a share) and retains $3 million for reinvestment in the business. In 1949, 1950, and 1951 it does exactly the same.

By 1952, Company B has reinvested a total of $12 million—six

times as much as Company A. As a result, it's developed and manufactured a successful new product. So earnings in 1952 are up: Where the company previously earned $1 a share, it now earns $1.50. And with this big increase in earnings, it raises the dividend to 60 cents a share.

What does this mean to the stockholder? In 1948, Company B's stock sold at $10 a share. Since it paid a 40-cent dividend on a $10 investment, its yield was 4 per cent.

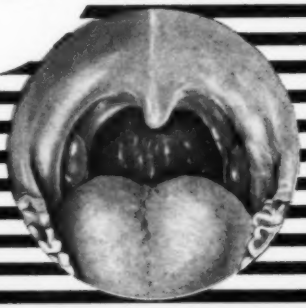
In 1952 it sells at $15 a share. And with its 60-cent dividend on a $15 investment, its yield is still 4 per cent.

But look at the capital appreciation. Suppose an investor had bought ten shares of Company B stock in 1948 for $100, then sold them in 1952. He'd have gained $72 on an investment of $100—a gain of 72 per cent in five years.

That's a gain of about 14 per cent a year, of which 4 per cent is from dividends and 10 per cent is from capital appreciation.

So we're beginning to see what direction our investments must take if we're to maintain purchasing power by getting at least a 9 per cent return.

And the higher the tax bracket a doctor's in, the better off he is by buying growth stocks. That's because of his capital gains, on which the maximum tax is 25 per cent. [MORE ▶



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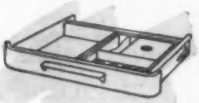
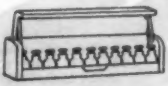


Racks for medicine bottles, for example, keep them safely out of your way yet instantly at hand . . . Every cabinet has a drawer equipped with convenient insert for treatment supplies.



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Bert Seligman, Clinical Experience with Trypsin. (1)
"A salutary effect on the thrombo-phlebitic process was elicited. The per patient hospital stay averaged 19 plus days for those not receiving trypsin, against 9 plus for those who did receive it."

H. T. Golden, Effective Treatment for Traumatic and Inflamed Lesions Using Trypsin. (2)
"In comparison with results obtained before trypsin was used routinely, there has been a relatively rapid subsidence of swelling, dissolution of hematomata, and relief of pain."

I. Innerfield, Intramuscular Trypsin-in-oil in Acute Thrombophlebitis, Diabetic Cellulitis and Leg Ulcer. (3)
"Parenzyme was administered to ninety patients with acute thrombophlebitis, diabetic cellulitis, and indolent leg ulcer. In this study, striking reduction and reversal of acute inflammation was a constant finding."

H. M. Fisher, Parenteral Trypsin in Peripheral Vascular and Thromboembolic Diseases. (4)
"The results have been uniformly good in 75 of the 80 patients. In many cases, relief was noted within the first twelve hours after treatment was instituted."

F. N. Campagna and J. M. Hopen. Trypsin in Ocular Disease Effects in 63 cases of hemorrhagic and Inflammatory Conditions. (5)
"It (intramuscular trypsin) is effective in extraocular trauma, uveal tract inflammation, in anterior and in some posterior chamber hemorrhages of recent origin."

H. T. Golden, Intramuscular Trypsin. Its effect in 83 Patients with Acute Inflammatory states. (6)
"Only 2 of the 83 cases can be classed as treatment failures."

C. J. Wildman, Intramuscular Trypsin in the Treatment of Chronic Thrombophlebitis. (7)
"Through intervention in the chemical and enzymatic phase of the circulatory mechanism, it (Parenzyme) eliminates collateral edema and hyperemia and tends to re-establish the integrity of the local circulation, allowing all processes of repair—to proceed unimpeded."

REFERENCES

1. Ohio State Med. Journal *51*, May 1955. 2. Clinical Med. *2*, June 1955. 3. Surgery, 36:1090, Dec. 1954. N. Y. State Journal of Medicine 54:659, Mar. 1954. 5. Delaware State Med. J. 27:50, 1955. 6. Delaware State Med. J., Oct. 1954. 7. Angiology, Oct. 1955.

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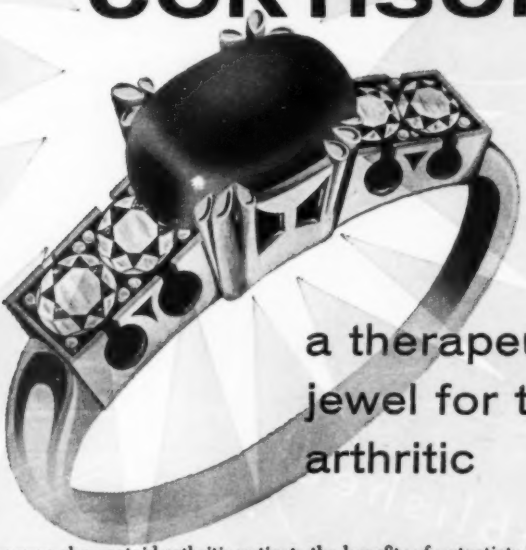

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Cortisone Acetate . . . . . 5 mg. (1/12 gr.)
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Literature on request

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Let's say that two men are in the 50 per cent tax bracket. In 1948, one invests $180 in Company A; the other invests $100 in Company B. Each gets ten shares. They sell their stock at the end of 1952, with these comparative results:

Net Gains Compared

From Company A (the income company), the first man has a total gain of $66. Here's how taxes reduce this amount:

Gain	Tax Rate	Actual Tax
$46 (dividends)	50%	$23
$20 (capital gain)	25%	$ 5
$66		$28

After taxes, therefore, the first man is left with only $38 of his profit ($66 minus $28). This is an after-tax return (on $180) of about 21 per cent in five years—or 4 per cent a year.

Now let's see how the second investor has fared. From Company B (the growth company) he has a total gain of $72. Here's how taxes affect this profit:

Gain	Tax Rate	Actual Tax
$22 (dividends)	50%	$11
$50 (capital gain)	25%	$12½
$72		$23½

So the growth-company investor is left with $48.50 after taxes. This is an after-tax return (on $100) of about 48 per cent in five years—or over 9 per cent a year.

Just how well have growth stocks

"I'm already pushing 50. That's enough exercise for anyone!"

done over the years in preserving the purchasing power of invested money? The record shows that they've done very well indeed.

Take International Business Machines, for example: In 1953 it sold for almost five times its 1942 price. Standard Oil of New Jersey did even better: In 1953 it sold for more than five and one-half times its 1942 price. Other recognized growth stocks like DuPont de Nemours and General Electric did almost as well.

Suppose in 1942 you had invested $100 in these four stocks—$25 in each. Even if your dividends over the next eleven years amounted to only about 1 per cent annually, your return by 1953, counting in capital appreciation, would have totaled $460. This assumes that you bought at 1942's low and sold at 1953's high. But let's admit that the average investor isn't astute enough for that. Let's say his imperfectly timed buying and selling reduces his return from $460 to $221.

Even this is $121 more than his original investment. It represents *an annual return of 11 per cent.*

The purchase of sound growth stocks will take you a long way toward your goal of preserving purchasing power. Currently, perhaps four-fifths of your investments should be in such securities.

What about the other fifth? Consider putting that into strictly *spec-*

ulative issues. These are the kind bought with little regard for annual income or safety of principal. You buy these stocks "to make a killing."

Most investors have a strong desire to speculate. Sooner or later, this urge will govern some of the purchases that just about everyone makes. Since that's so, it's worthwhile here to mention a couple of basic principles you should follow, and to point out some of the pitfalls.

The basic principles are these:

¶ Limit speculations to a small percentage—say, 20 per cent—of your total market investment. Then, if the risk turns out badly, you won't have suffered a crippling money loss.

¶ Even in speculations, investigate before buying. Take the Canadian oil companies: Fortunes can be made in some of these. But while a few have merit, dozens don't.

How can you pick the winners? Read the readily available comparison studies and then consult a competent investment advisor. That way, you'll find which companies have competent management, promising acreage to explore, and sufficient money for operations.

And now for some of the pitfalls:

Following "tips." Most often these lead to poor results. I recall the tip that led my father-in-law into his first and only stock-market venture: Kaiser-Fraser was going up! He hurriedly bought 100 shares—a $2,200

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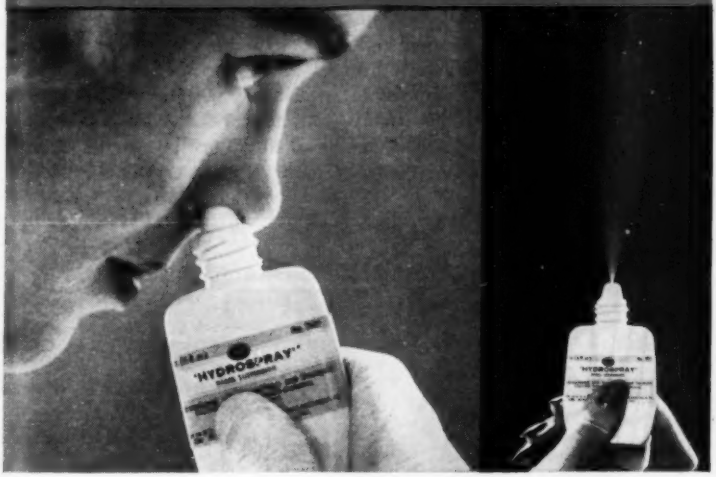
MAJOR ADVANTAGES: New synergistic anti-inflammatory, decongestant and antibacterial formula. High steroid content assures effective response.



Topically applied hydrocortisone[1] in therapeutic concentrations has been shown to afford a significant degree of subjective and objective improvement in a high percentage of patients suffering from various types of rhinitis. HYDROSPRAY provides HYDROCORTONE in a concentration of 0.1% plus a safe but potent decongestant, PROPADRINE, and a wide-spectrum antibiotic, Neomycin, with low sensitization potential. This combination provides a three-fold attack on the physiologic and pathologic manifestations of nasal allergies which results in a degree of relief that is often greater and achieved faster than when any one of these agents is employed alone.

INDICATIONS: Acute and chronic rhinitis, vasomotor rhinitis, perennial rhinitis and polyposis.

SUPPLIED: In squeezable plastic spray bottles containing 15 cc. HYDROSPRAY, each cc. supplying 1 mg. of HYDROCORTONE, 15 mg. of PROPADRINE Hydrochloride and 5 mg. of Neomycin Sulfate (equivalent to 3.5 mg. of neomycin base).

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* **60**:431, Oct. 1954.

investment. In 1952, he sold them for $400. And in all that time, he received not a penny in dividends!

The typical tip takes this form: "Buy Company X. Its officers are buying in heavily."

Be skeptical of the transactions of "insiders." Information on their dealings comes out too late to be useful. Furthermore, corporation directors are notoriously poor judges of the future action of their companies' stocks.

Trying for short-term gain. This means betting on your personal ability to forecast the immediate future of the market. It's almost impossible to pull off successfully. Too many imponderables—politics, strikes, international relations, etc.—control week-by-week price movements.

There's one other type of investment that the speculative investor should know about: It's called a *special situation*. By this is meant an opportunity to buy the stock of a company whose present value is not widely recognized.

Its value may exist in resources, patents, or top-quality management. And since these values *aren't* widely recognized, the price of the stock naturally doesn't reflect them. So the stock can be bought at bargain rates.

Short-term special situations have the same weaknesses I've pointed out above. But some *long-term* special situations have real speculative merit. Here's a case in point:

In 1946, Texas Pacific Land Trust was holding tremendous acreage worth at least $17 an acre. The geology was such that oil was almost certain to be found. At that time, the stock sold at $17 a share. This was truly a long-term special situation. And it paid off when oil was discovered on the property. By 1952, the stock had zoomed to $152 a share.

Today, too, such special situations exist. But you have to hunt them out—and this requires a profound knowledge of the business the corporation is engaged in. It requires, too, careful comparative study of financial statements, annual reports, and progress reports of all companies in the same business. Obviously, such analysis is beyond the capabilities of most doctor-investors.

Now let's briefly sum up the major points of this article:

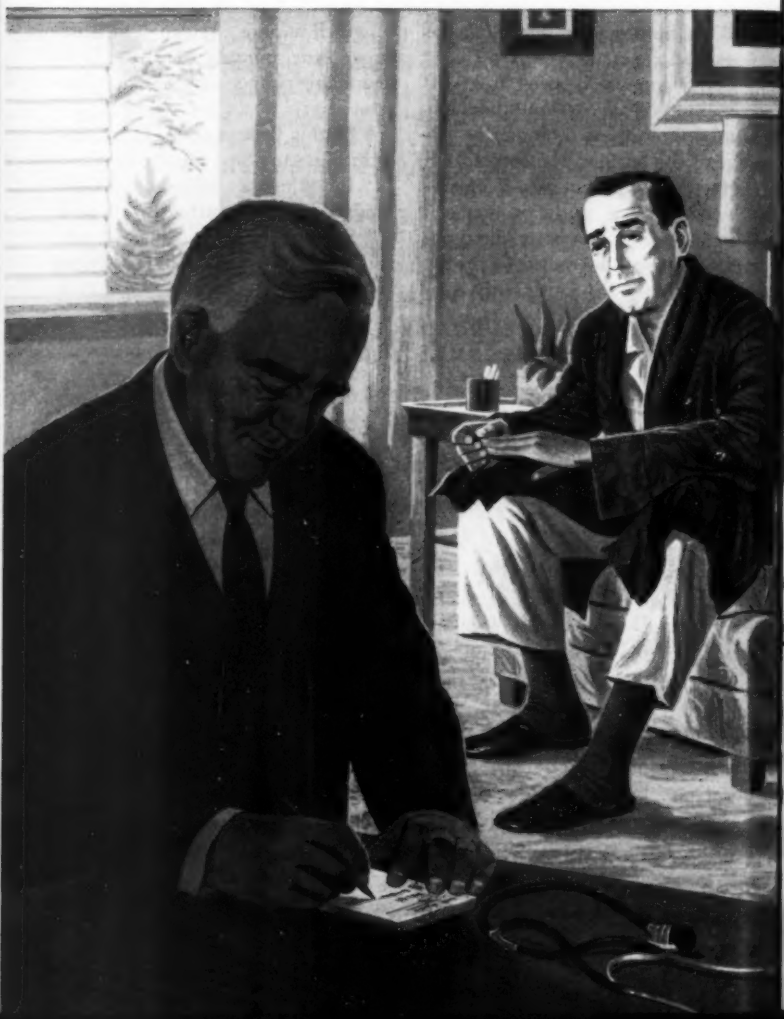
The physician's investment aim should be to preserve—and, if possible, to increase—the purchasing power of his invested dollars. This may well require a return of at least 9 per cent annually. He stands a reasonable chance of achieving that return by:

¶ Putting little or none of his money into income-type investments;

¶ Investing, say, 80 per cent of his funds in sound growth stocks; and

¶ Risking no more than 20 per cent of his investment funds on carefully speculative issues. END

BACK ON HIS FEET BUT STILL SICK.....



The Problem of Residual Anemia

in Upper Respiratory and Other Infections

The persistent anemia which you so frequently see in association with an infectious process demands serious consideration since it "favours the development of further infection and may retard convalescence."[1]

Noteworthy is the slow recovery of the anemic patient following viral or bacterial upper respiratory involvement.

Cobalt appears to be the only known agent capable of stimulating the depressed bone-marrow function typical of post-infection anemia.

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Continuing Clinical Proof of Effectiveness in Anemia Associated with Infection

"Cobalt appears to be a valuable drug in the treatment of anemias secondary to chronic diseases."[2]

"The marked increase in the early erythroid cells in the [children]...with anaemia of infection point to a direct stimulation of the erythroid tissue of the marrow as the main action of the cobalt."[1]

" . . . [cobalt] will force the bone marrow to make more cells even when nephritis or chronic infection are the causes of the anemia."[3]

"There is no doubt that given in sufficient dosage . . . [cobalt] is effective in alleviating the anemia secondary to infection, cancer, and renal disease."[4]

"In our hands, cobalt appeared to be a useful and valuable drug, well tolerated and devoid of undue toxicity."[2]

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Roncovite Tablets—red, enteric coated in bottles of 100. Roncovite-OB—red, capsule-shaped tablets in bottles of 100. Roncovite Drops—bottles of 15 cc. with calibrated dropper.

DOSAGE:

One tablet after each meal and at bedtime. Children, 1 year or over, 0.6 cc. (10 drops); infants less than 1 year, 0.3 cc. (5 drops) once daily diluted with water, milk or fruit juice.

REFERENCES:

1. Coles, B. L.: Arch. Disease in Childhood *30*:121 (April) 1955.
2. Weinsaft, P. P., and Bernstein, L. H. T.: Amer. J. Med. Sc. *230*:264 (Sept.) 1955.
3. Vilter, R. W.: Amer. J. Clin. Nutr. *3*:72 (Jan.-Feb.) 1955.
4. Cartwright, G. E.: Amer. J. Clin. Nutr. *3*:11 (Jan.-Feb.) 1955.

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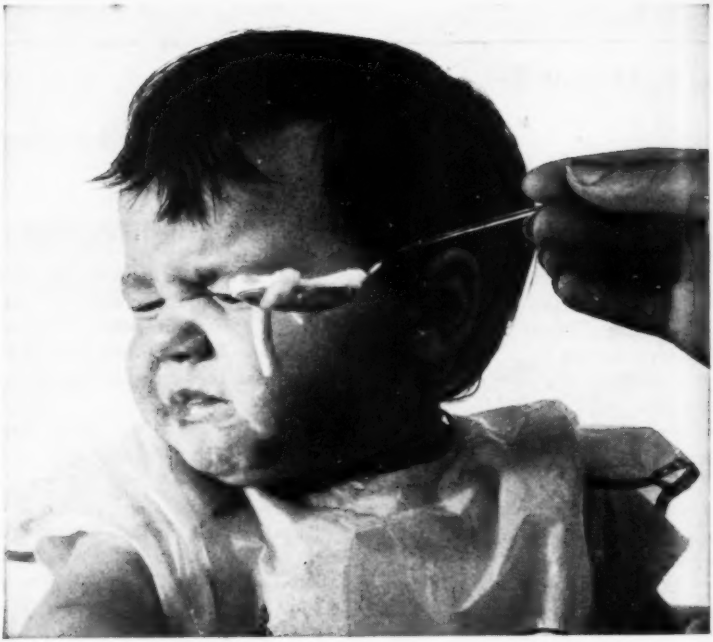

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Thiamine mononitrate	0.75	mg.
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Niacinamide	7.5	mg.
Vitamin B_{12}	2.5	mcg.
Folic Acid	0.25	mg.
Ascorbic acid	75	mg.
(from sodium ascorbate)		
Pyridoxine hydrochloride	0.75	mg.
Calcium pantothenate	7.5	mg.
Iron ammonium citrate green	50	mg.
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You've heard that allegation and others. But the facts are something else again, this surgeon's story indicates. Few doctors have described the economic realities of the specialty as well as they're described here

By Robert R. Robertson, M.D.

● Some wild and wonderful pot shots have been taken at surgeons lately. We've been told, among other things, that:

¶ They make too much money.

¶ They steal the referring physicians' patients.

¶ They get all the glory and none of the grind.

¶ They're only mechanics, anyway.

From my experience as a surgeon, I protest the above statements. I can't speak for all surgeons, of course. Some I wouldn't defend. But most of those I know carry heavy responsibilities, work hard for their patients in and out of the operating room, maintain good relations with referring physicians, and will not operate just for the sake of operating.

What's more, they're not getting rich.

My personal case history may help set the record

THE AUTHOR, *who writes here under a pen name, is a board-certified surgeon now practicing in Chicago.*

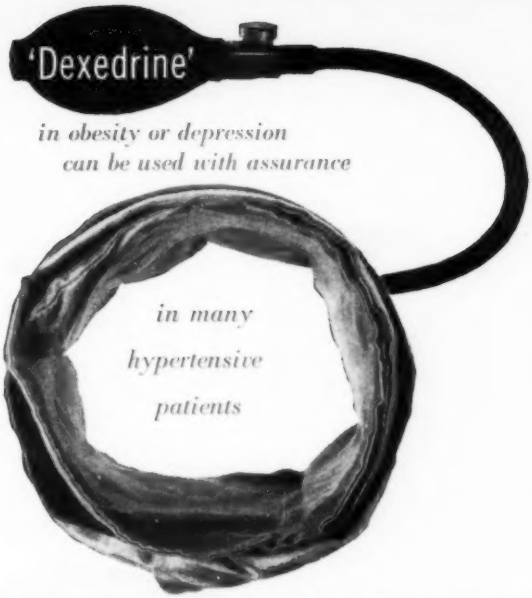
straight. I can't reveal my identity. But everything that follows is basically true, with only such changes as are necessary to preserve the anonymity of those involved.

To begin with, I'm 50 years old. I was nearly twenty years out of the University of Illinois College of Medicine before I reached the much-discussed median net income for surgeons of $16,000 a year, as revealed in the last MEDICAL ECONOMICS survey of doctors' incomes by specialty.

I serve on the attending staff of a West Side Chicago hospital. I'm also a consultant at one government hospital and on the teaching staff of another. I'm a diplomate of the American Board of Surgery and a fellow of the American College of Surgeons. In other words, I'm a qualified general surgeon.

I have an intelligent wife, two fine children, one medium-priced automobile, and a comfortable, $125-a-month flat in Oak Park. Only in the last two years have I seen a definite hope of reaching financial security in the next ten.

I believe I did a reasonably satisfactory job of learning the ideals of my profession and my specialty while I was a student. But my teachers taught me nothing about the realities of making a living from private practice—and I didn't think to ask. [MORE ▶



Dr. Ella Roberts, reporting in Am. Pract. & Dig. Treat. (5:606), states that she administered 'Dexedrine' to 76 patients suffering from hypertension complicated by obesity or depression. Frequent blood pressure readings were made.

At the end of a 2-year study, she concluded:

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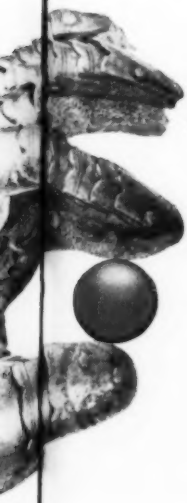

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As I see it now, every doctor has seven major decisions to make on the way to becoming a first-class surgeon:

Field of Practice

1. *Will he go into general practice, or will he specialize?*

Here, his ambitions may prove less weighty than the force of circumstance. For example, is he in debt for his medical schooling? Is he married? Does he have children? Can he support them while in training?

When I finished my internship, I was in pretty good shape economically. My father had managed to see me through. But from then on, I had to make my own way.

Though I had a natural interest in research, with some good ideas for endocrinological investigation, I saw no economic future in accepting a $2,000-a-year faculty appointment. Instead, decided to go into general practice.

I had married as soon as I got my M.D. degree. My wife-to-be and I had gone together five years. We had nearly broken up several times because of my enforced indecision. Mary wasn't wealthy. She didn't want a professional career. She just wanted to make a home.

I realize now that the young physician would make life easier for himself if he kept from falling in love until he completed his training. Of course, if he falls in love with a rich girl, they can marry at any time

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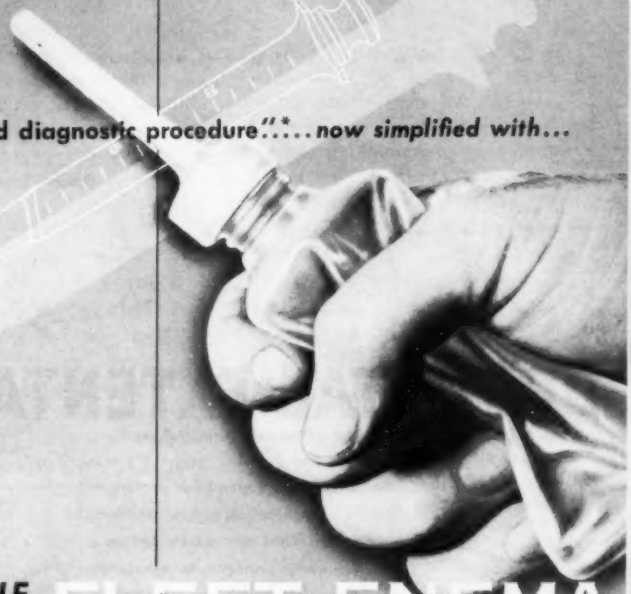

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(though I've heard it said that the man who marries for money earns it).

On the other hand, it doesn't seem wise for a student to marry a working girl who'll see him through training. You don't have to read "Not as a Stranger" to be aware of the strain this causes. Gratitude is a wobbly crutch at best. And what if your working wife gets pregnant?

After my interneship, I opened an office as a general practitioner and meanwhile found a preceptorship in surgery. It's been argued that every specialist should start as a G.P. But I discovered that general practice was no way to support a wife whose cash wedding gifts I'd spent on office equipment.

Soon I realized I wasn't cut out to be a G.P.—not a good one, anyway. For one thing, I didn't like pediatrics. In the end I became a surgeon, more or less through trial and error.

Path of Training

2. *Where will he get his special training?*

Some fine surgeons in this country began as general practitioners. They got their training the hard way, on their own time, by watching surgery and scrubbing in when they could. But they didn't stop there.

Most found it advisable to choose their teachers as carefully as they'd choose a surgeon to open the heart or the head. Human beings learn chiefly by imitation. So, during several years with one operator, the student is likely to adopt *all* the latter's habits—good or bad.

I have seen G.P.s in a small hospital who shopped from one routine operation to the next—and wound up as homemade operators. The men they assisted were only occasionally interested in teaching whatever they themselves knew.

Essentially self-taught, the homemade surgeon learns all the right answers. But he learns few of the right questions.

The main thing he knows and boasts of may be his manual dexterity. This isn't enough to make him a surgeon, though. He also needs the discipline and judgment that come from watching masters work themselves in and out of all kinds of situations, where one slip can ruin the patient.

Unless he has a chance to learn varying approaches to each condition, and the relative successes or failures that may come of each approach, the homemade surgeon tends to become a potential repeater of everybody else's mistakes. He isn't the man who can reduce a given operation's mortality rate from 3 per 100 to 3 per 1,000.

This is why the well-rounded resident training programs hammered out by the A.C.S. and the A.M.A. are so important in the making of today's surgeons. With few exceptions, qualified surgeons depend on qualified teachers.

It was my good fortune, professionally if not economically, to be

offered the chance to understudy a professor of surgery in one of Chicago's best teaching hospitals. For six years, I did his scut work. I examined patients, read X-ray films and laboratory reports, assisted at the operating table, made rounds and house calls, answered questions, and asked questions. In the third year, the doctor let me begin doing some major operations myself.

He didn't pay me a cent for this. Nor did he give me a word of advice on how to build an ethical practice, like his own. So I became a master surgeon and an economic dunce. I scraped along financially by doing a little general practice in the afternoons and evenings.

My chief did recommend me for a staff appointment in a small hospital, and I got the appointment. In the first year that I held myself out as a surgeon in the less major procedures—my second year in practice—I did around twenty-five operations, or about $4,000 worth of surgery. I got by.

Choice of Location

3. *Where will he practice?*

I was determined to ask favors of nobody. Having been reared and educated in Chicago, I wanted to practice surgery there.

I didn't know it at the time; but when the doctor settles for independent practice in a metropolitan

from disability to dexterity

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area, he settles for a lot of competition and a low average income.

If I were a young surgeon today—rather than a sadder and wiser middle-aged one—I'd look for a small city, with 25,000 to 100,000 people, and with a good hospital. I'd try to find a place not too overpopulated with qualified surgeons.

I'd talk to some of the specialists there. Would they make room for me? Or might I run into a squeeze-out?

I'd talk to some of the G.P.s, too, and learn what, if anything, they'd expect of me. Would they prefer to do most of their major surgery themselves? Would they like to refer patients to a man of my training? Would they wish to assist, or to split fees? I now know that in some places the G.P.s insist on some sort of deal, while in others they're horrified at any such idea.

The big trouble with many men is that they choose a place to practice without adequate reconnaissance. Then they take their licking, as I did when I settled in Chicago.

Beginning Economics

4. *How will he get started in practice?*

I'm an authority on getting started in practice. I've done it three times: following interneship, following military service, and again—four years ago—when I became the partner of a senior surgeon with a large practice.

Such a partnership is the ideal

way for the young or even the middle-aged surgeon to begin. Or, if not a partnership, a staff membership in a legitimate clinical group. Either way, the surgeon gets an opportunity to keep his hand in and to meet his financial needs from the outset.

The arrangement may be a straight salary, salary and share of the net profits, or a fixed percentage division of all income. What's most important is some assurance of advancement. Any arrangement that makes no such provision invites future trouble. Unfortunately, the number of surgeons being trained exceeds the available number of satisfactory partnership openings.

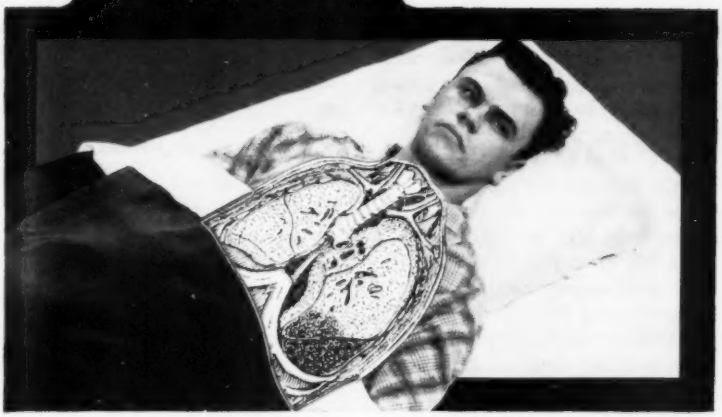
I began as a solo practitioner, of course—and in the days before the American Board of Surgery was founded. That was a break for me: I don't see how any surgeon who begins in independent practice, as I did, can limit himself 100 per cent to his specialty, as the Board now requires.

The A.C.S. rule of reason is much more practical. It allows the general surgeon to do some general practice, depending on the custom of his community, as long as his major effort is surgical.

At the start, my patients were relatives and friends—a limited potential source of surgery. It was a year or two before I got any referrals.

[MORE ▶

ANATOMY OF DISEASE



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Perhaps I wasn't a good salesman. The young man needs more than a demonstrable competence. He must also have an aggressive and winning personality; he must make many social contacts with doctors and laymen; he must go to parties and give parties himself.

By the time the war came, I was doing only fifty to sixty majors a year. My gross was $9,000 to $10,000, with surgery making up 80 to 90 per cent of it.

While I was overseas during the war, working with combat casualties, I got lots of letters from colleagues who were keeping the home fires burning. They told me to hurry back, that they needed my help. But when I at last returned, I found they would have preferred not to see me even walk into the hospital. They had, in a phrase, cornered the market.

Post-war Pickle

For the second time, I started building a practice from scratch. Now there were no well-wishing friends or relatives to send me patients—and there were no referrals from other doctors. Unlike the surgeon with ten or more years of continuous practice in one place, I also lacked a substantial following of satisfied patients.

In the first year of my return to civilian practice I grossed about

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$8,000 (worth about $4,000 in pre-war purchasing power).

Then I realized that I had to have referrals or go broke. So I tried splitting fees.

Price of Ethics

5. *What will he be willing to do in order to make money?*

I had taken the anti-fee-splitting pledge of the A.C.S. seriously. As has been said elsewhere, however, it is the history of morality that high purpose surrenders to economic necessity.

The hungry surgeon—in Chicago, at any rate—finds himself becoming increasingly friendly with the doctor who will gladly refer a patient for a split of the surgical fee.

When I first began specializing, before the war, I took space in a large office suite in the Loop. Both an internist and an obstetrician in the same suite offered to refer surgical cases to me if I'd give them 50 per cent.

"I'm not built that way," I said.

"You're nuts," they told me.

After the war, when I was nearly on my uppers, I surrendered—briefly. I split with a general practitioner and two internists in about ten cases. One man sent me the patient, col-

"... the clavicle connected to the scapula, the scapula connected to the humerus, the ..."

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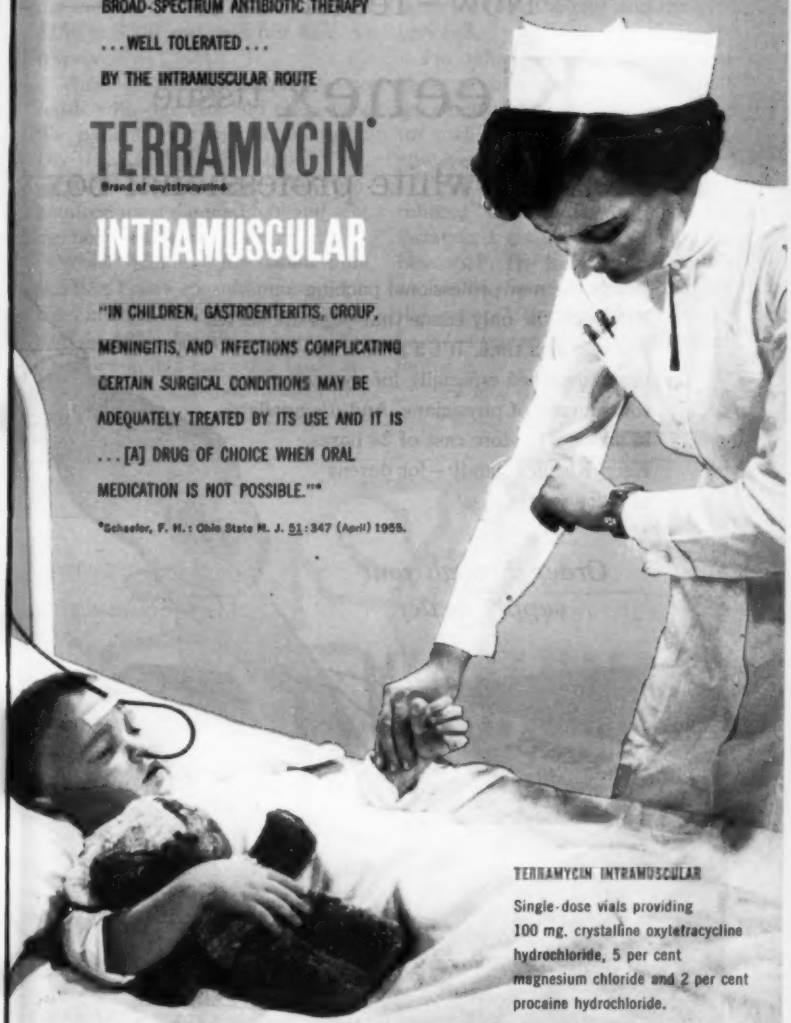
*Schaefer, F. H.: Ohio State M. J. 51:347 (April) 1955.



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lected the bill for me, and paid me $75 to $150. Another told me to render the bill for some such amount as $150 to $300 and send him half. So it went.

These gentlemen didn't want to scrub with me. Nor did they want the patient informed of the split. One day I told them I couldn't work on that basis any more. They pronounced me a damned fool and sent me no more cases.

While looking for simon-pure practice, I got a consultant's appointment in a government hospital. This paid me $25 a day for any part of the day I worked. I carried a fairly active operating schedule three or four times a week. To this I added a $200-a-month, part-time medical administrative job. So I had enough money to pay the rent and the grocery bill.

I'm telling you, remember, not about a pup surgeon who might have been willing to scratch around for a while. I was a master surgeon, now well past 40.

I can't say that I lacked "opportunities." One Sunday afternoon, for instance, I got a phone call from a busy G.P. He had a patient with cancer of the uterus. Would I see the patient? If so, he'd arrange to have her sent on my service the next morning.

"Tell me," I asked, "why did you call *me?*"

[MORE ▶

"Mutual friends think highly of you," he said.

"I'm curious," I said. "I know you've been sending your cases to —" (I named the associate of a surgeon well known in Chicago as a sort of professor of fee splitting. His practice was reputed to gross $250,000 a year. I don't know whether this was before or after his 50 per cent kickbacks.)

"You should know that I don't split," I added.

There was a dead silence on the other end. So I continued: "Perhaps you'd like to think it over and call me back if you want me to go ahead."

He didn't call back.

A few months later, an elderly surgeon called me. Preparing to retire, he was reorganizing his office as a "clinic." He had put a G.P. in charge, and now he offered me the surgical schedule. It amounted to 500 or 600 cases a year. The "clinic" would collect the bills and pay me a flat fee per operation.

I said no.

Later, I learned of a case in which the "clinical director" of that organization billed a patient $450 for surgery. Then he paid the surgeon who took the job $150.

Again, a G.P. who headed a group practice offered me the group's surgery for a percentage of the fees collected. This time, I thought the offer over more carefully. But again I concluded it was unethical.

This isn't intended to be a moral homily on fee splitting. Fee splitting is like the weather: Everybody talks about it nowadays, but nobody does much about it. Nevertheless, I feel certain that if I hadn't been brought up in a rigidly moral family, and if I hadn't been taught that surgeons should be chosen on merit alone, I should now be making $50,000 to $60,000 a year. Such is the price of self-respect.

Income Goals

6. *How much does he want to make?*

At 50, I net around $20,000 a year. So I can see my son and daughter through college and maybe buy a house.

About two years ago, I found an older surgeon whose ethical views fitted mine. He had a large practice not built on referrals, and he wanted a junior partner. All the surgery we do is necessary. (I'm sorry I can't describe the work further without identifying myself.)

You may sometimes hear of a surgeon who does 1,000 or even 1,500 major operations a year. But an ethical Chicago surgeon considers he has a good practice if he does 150. Very few do as many as 200 or 300. I'm sure that only two out of the twenty-five surgeons in my hospital gross $50,000 or more.

The average fee for a major operation in Chicago comes to about $150, with due allowance for small cases, free work, and bad debts. This means a gross of $22,500 and

a net of $16,000 for the man who does 150 majors a year.

This is all the well-trained surgeon can reasonably expect in his first five to ten years of practice.

Naturally, I hear about fees of $750, $1,000, $1,500, or $2,500. But I don't charge them, and I don't know anyone who does. The ethical surgeon with an inflated income is a rare bird in my town.

Some surgeons have a tendency to overcharge because they get so few cases; but high fees of this sort don't add up to much. Other surgeons believe they'll get more work if they keep their fees at rock bottom. This would probably prove true if there were free competition. There isn't.

Practice Standards

7. *What kind of surgeon does he want to be?*

A doctor ceases to be a good surgeon when he loses the right of independent judgment. This right extends from diagnosis to fee.

And here's where I pick a bone with Dr. Herbert Berger. In his article, "Are Surgical Fees Too High?" (MEDICAL ECONOMICS, June, 1955), he says the decision to operate shouldn't be the surgeon's, because the surgeon has a financial stake in the decision. He adds:

"Some surgeons may resent being viewed as highly skilled artisans rather than diagnosticians. But such is probably their rightful place in the medical hierarchy."

Such is the recipe for poppycock!

I have never known a surgeon to do unnecessary surgery deliberately, just for the fee. In my observation, wherever the operation couldn't be subsequently justified, the fault lay in diagnostic error.

Surgeon's Choice

The problem, then, is this: How can we increase the probability of correct diagnosis? Is medical or surgical treatment the better approach? And if surgical treatment is the answer, what is the *best* surgical procedure?

These are decisions that the surgeon is, or should be, trained to make.

Surgeons are, I admit, naturally biased toward surgical intervention. But this bias is shared by G.P.s who do surgery, assist in surgery, or expect a secret split. To accuse a surgeon of deciding to operate because it means a fee is like accusing an internist of recommending a conservative, wait-and-see approach in order to run up the patient's medical bill.

The place where both the referring physician and the surgeon can save money for the patient is in diagnosis. A.C.S. investigations of various hospitals have shown that diagnostic error in operations for acute appendicitis may vary anywhere from 5 to 50 per cent.

This means that in 1,000 operations at $150 each, with a 5 per cent error, patients would pay $7,500 in surgical fees without benefit to their

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health. With a 50 per cent error, they'd be throwing away $75,000.

So, I submit, *good surgical diagnosis* is the way to keep sickness costs down. And where the surgeon does such diagnosis himself, the fee for it is as logically his as are fees for the operation and aftercare.

There are two eminently practical reasons why the qualified surgeon can never surrender the right to decide whether he should or should not operate:

A. The maximum in successful treatment and the minimum in mortality, morbidity, and treatment failures can be obtained only if the surgeon assumes responsibility for the operating diagnosis and the eventual result, as well as for the operation itself.

B. The surgeon can't subordinate his interest in following the case from admission to recovery as long as the courts hold him responsible. And, as the operator, he *is* held responsible for the fate of the patient in the event of a malpractice suit.

Justifiable Gripe

All this, to be sure, doesn't relieve the justifiable annoyance of the referring physician who carefully, thoughtfully, conscientiously works up a diagnosis over a period of time —and who then sees the surgeon step in, become the hero, and knock off a much larger fee.

In such cases, the surgeon deserves criticism. When the surgeon is called in, the patient or his family is inclined to give him entire direction of the case. Thus, the medical man may feel that he has lost face. Still worse, he may have lost any hope of getting the patient or the family back.

I have always insisted on carrying out the true role of the consultant. The consultant is called in and offers his opinion. But he avoids taking over until his recommendation is accepted and he's selected as surgeon.

Thereafter, he shares his interest in the case with the referring physician. And he shows the family that he respects their doctor.

What I'm saying is simply this: The good surgeon is first of all a good physician. [MORE ▶

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In these, the trio plays a solo—

Eggs baked in pimiento-flecked cheese sauce are gay and tempting.

A casserole of eggplant and tomatoes layered with cottage cheese and topped with grated parmesan makes a satisfying entree.

Eggs poached in tomato juice can be served in a soup bowl with a frill of chopped parsley on top.

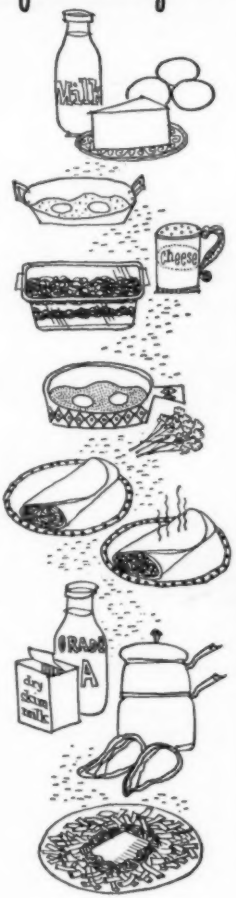
In these, the trio plays accompaniment—

Ham 'n egg rolls come hot or cold. For hot, roll a warm slice of ham around scrambled eggs. For cold, roll ham around egg salad mixed with cottage cheese.

Oyster stew can be creamy without cream when the milk is bolstered with dry skim milk powder. A pinch of thyme adds savor.

Broiled salmon or tuna-burgers nestle nicely in a nest of noodles. A slice of cheese on top broils to a bubbling brown.

These suggestions are only a few of the possible combinations of this versatile trio. And the adequate protein nutrition they make possible, plus a liberal intake of fluids, may help establish a regimen that will please you both.



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On the whole, I've found internists and G.P.s alert to the welfare of the patient and eager to see him given the best surgical care. On this basis, the medical men are easy to work with.

I'd hate to think that they're out to make a brighter place in the sun for themselves just by tearing *me* down.

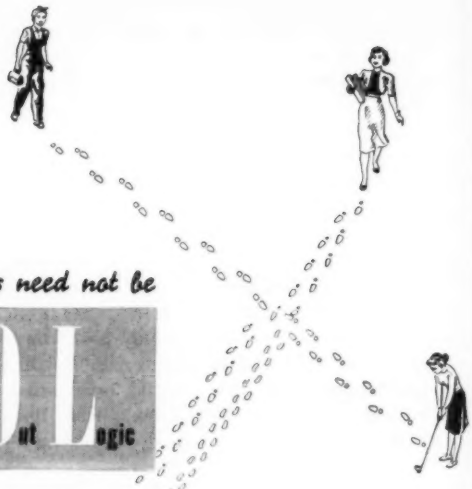
Conclusion: Where does the trouble lie?

When I went into practice the first time, I made my biggest mistake in not seeking the advice of established surgeons who could explain the business side of medicine to me. I made my economic decisions from ignorance. And that's a poor way to determine the whole future course of one's life.

Fundamentally, my error—which has been shared by too many of my colleagues—is a failure of medical education. Our medical schools and teaching hospitals do a good job, by and large, of training us in the technical aspects of diagnosis and treatment. They also hand us a code of ethics and require us to sign a pledge. But then they say: "Go to it, little lambs."

Is it any wonder that some of us wind up feeling like black sheep?

If I had it to do over again, I'd still insist on obeying the Golden Rule. But I'd want some tips on how to keep it polished. END



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ME-16

'YOUR BEST MALPRACTICE DEFENSE'

By William F. Martin, LL.B.

This attorney cites examples—direct from the courtroom —to show how detailed records and written advice to patients can protect you against malpractice judgments

● I've seen dozens of medical malpractice cases won or lost on the basis of a doctor's records—or lack of them. Just recently, for example, an EENT man was sued by an elderly patient for having allegedly operated on the wrong eye. The issue in court was simply whether the patient had consented to the removal of a cataract from his right eye or his left eye.

It was one man's word against another's. The physician's case records might have tipped the balance in his favor—if they'd made sense. But his written notes placed the more serious cataract three times in the right eye, and four times in the left! Naturally, the verdict went against him.

An unusual case? I wish it were.

According to a recent study, only one in *eight* malpractice suits reveals actual negligence on the doctor's part—but the doctor loses one case in *four*. Why the discrepancy? The medical society study group places much of the

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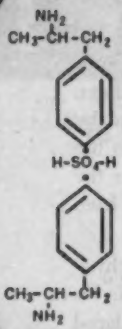
THE AUTHOR *is chief legal counsel to the Medical Society of the State of New York.*

1938

first, amphetamine

1945



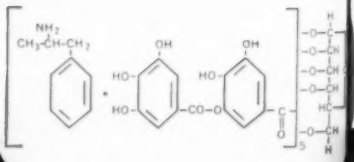
then,

dextro-

amphetamine

and now tanphetamin

protocolloid complex



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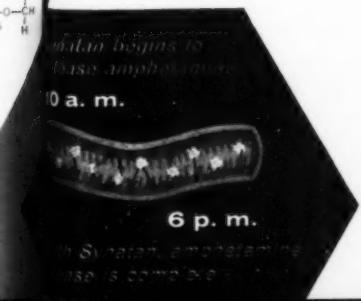

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blame on the doctor's "failure to keep adequate, detailed records."

As a lawyer with long years of courtroom experience in malpractice cases, I agree. I'm convinced that your best malpractice defense is a carefully-kept file of legible, logical, and complete medical records.

What do I mean by "complete"? Here are the recommendations I make to doctors who ask my advice about record-keeping:

1. *It pays to record every basic fact in every case, with particular attention to names and dates.*

No jury believes that a busy physician can possibly remember the history, examination, and treatment of all his patients. But many a jury believes that the patient *can* recall the details, since the experience in question happened uniquely *to him.*

What to Record

So even if you've got a wonderful memory, it won't do you much good in court. It won't convince the jury. For that, you need written records of the patient's complaint, the physical findings, and the treatment prescribed, plus copies of laboratory, X-ray, and consultants' reports.

One physician found out these truths when he was sued after treating a fracture of the tibia. Though the result wasn't perfect, the physician had apparently done his best. He might have convinced the jury if his records had included the basic data. Instead, there were some serious omissions:

He had recorded the type of accident, but not the date. He'd mentioned taking X-rays before and after applying the cast, but no X-ray report was included. He had no record of a physical examination. And although he acknowledged the patient's temperature had been high for several days, the doctor's own progress notes read: "Patient's condition satisfactory."

Obviously, such records weren't much help to the defense. It wasn't enough for the doctor just to *say* he'd done all he could; he needed more concrete evidence. Because he couldn't produce it, the patient was awarded $5,500.

I've known other cases in which the doctor had no record at all of treating a patient who later sued him. Apparently, the busiest medical men are sometimes too rushed to jot down even an essential name.

No physician can afford to be *that* busy.

Consider, by way of contrast, a case in which a practitioner was well repaid for having kept detailed notes:

The doctor was sued following a cystoscopic examination. The patient alleged he'd been infected and had suffered fever as a result. But the doctor's records proved that every known means of investigation had been used to find out whether there was a urinary infection—and there wasn't.

His records also showed that the patient had reacted with fever to

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sulfathiazole, and that his temperature had returned to normal after use of the drug had been discontinued. Dates and temperatures were included in the record.

The jury's verdict was for the physician. His written notes clinched it.

Make It Clear

2. *It pays to write out complicated instructions, or any instructions to balky patients.*

After examining a woman's injured foot, one doctor advised immediate X-rays. The patient refused because of the expense; she insisted that X-rays weren't necessary with so trifling an injury. The doctor warned her of the possible consequences, but he failed to note his warning on the patient's record.

The foot turned out to have been fractured. And the patient sued, alleging the doctor had opposed X-rays for "so trifling" an injury.

Indignantly, the doctor told the jury what he'd actually said. But he could produce no written proof, and the jury sustained the patient. She was awarded $2,200—which, by the way, came out of the doctor's own pocket. He carried no insurance.

When you put it in writing—with a carbon copy for your file—you're protected against the patient's misunderstanding. You may be protected against the jury's misunderstanding, too. Remember that oral evidence alone has led juries to some wild conclusions.

I learned this lesson years ago, in a case I've never forgotten. The plaintiff was a rather disheveled-looking woman in her early thirties. The physician I was defending was a handsome, trim gentleman. He was obviously so disdainful of the jury he didn't even try to explain the case in layman's language.

The woman complained that my client had applied a heat lamp to her abdomen, and in so doing had burned her. The doctor denied burning her. Anyhow, no burn had been discernible on examination several months later. All this was oral evidence—no written records.

The question before the jury was simple enough: Should the plaintiff be awarded $500, or nothing at all, for her alleged injury? But eight hours after the jury took this question under advisement, the verdict still hadn't come in. Puzzled, the judge asked the cause of the delay.

In reply, the jury sent out this note: "Dear Judge, we find both parties guilty of an abortion. But we don't know what to do about it. What do you suggest?"

Then and there, I made up my mind that I would never forget to warn my physician-clients of the need to explain *everything* in language a jury could understand. When such explanations can be put in writing, so much the better.

3. *It sometimes pays to make clear to the patient in writing that you're not guaranteeing the result.*

I recall a suit following an operation to produce sterility. The woman

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alleged the doctor had guaranteed a perfect result, but she had become pregnant three months later. If the doctor had disavowed any such guarantee in writing, there'd have been no ground for suit.

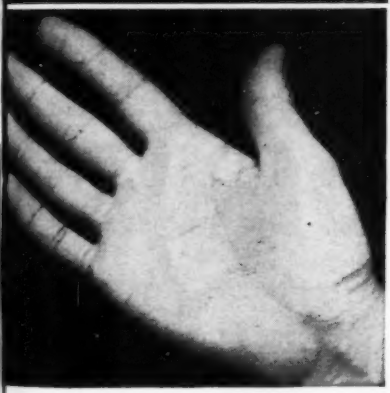
In case you find it medically necessary to tie off the uterine tubes, be sure the patient understands the limitations of the procedure. And be sure she signs her name to the understanding.

Following such an operation in Chicago recently, the mother of five children unexpectedly gave birth. She sued the doctor not only for malpractice, but also for support of the sixth child!

Without something in writing, alleged-guarantee cases are hard to defend against. Then, too, they may not be subject to the statute of limitations. Here's an example:

Several years after removing a tumor from a woman patient, a doctor was sued by her. He invoked the statute of limitations, which would have voided an ordinary malpractice action. But the plaintiff claimed a *breach of contract*, on the ground the doctor had promised a cure. So the case went to court. The ruling:

"A doctor and his patient are at liberty to contract for a particular result. If that result be not attained, a cause of action for breach of contract results . . . [This] is entirely separate from one for malpractice,



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although both may arise from the same transaction.

"The damages recoverable in malpractice are for personal injuries, including the pain and suffering . . . In the contract action, they are restricted to payments made and to the expenditures for nurses and medicines or other damages that flow from the breach thereof."

4. *It sometimes pays to keep records permanently.*

You probably know the statute of limitations in your state. But perhaps you don't know all the exceptions to it. The statute doesn't protect you in cases involving concealment, fraud, or a minor, for example.

Broadly speaking, therefore, it's best to retain case records of active patients indefinitely.

Even if your records aren't perfect, keep them. And remember that even illegible notes are better than altered ones.

One doctor I know filled in the patient's address just before his case records were subpoenaed. Asked in court when he'd written the address, the doctor casually replied: "Three years ago, when I treated the patient."

Whereupon the plaintiff's counsel demanded: "Then how do you account for the fact that my client just moved to that address three months ago? That's all."

And, for the doctor, it was. END

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Professional Courtesy Bows To Blue Shield

By Hugh C. Sherwood

Some doctors are now paying for treatment through insurance. It doesn't cost any more than their token gifts used to; and they believe it saves embarrassment

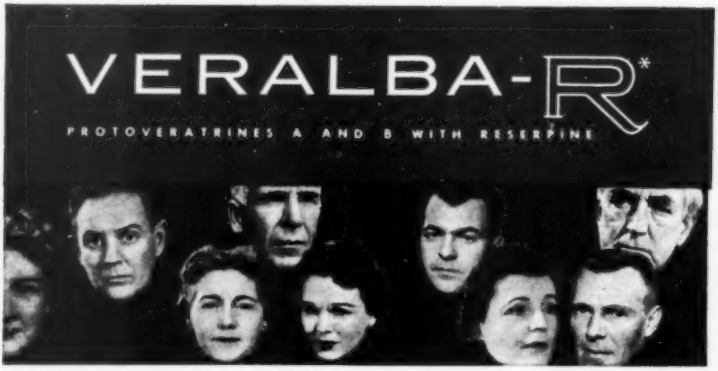
● Not long ago, the small son of a radiologist stumbled and fell on a sidewalk near his home in Trenton, N.J. The boy's head was lacerated in the tumble. So his father rushed him to a local surgeon.

After the child's head had been bandaged, the radiologist told the surgeon that Blue Shield would pay him for his service. At first the other man couldn't believe it. Then he said he couldn't accept it. He said he didn't think it was right to take money from a doctor.

Less than three weeks later, however, a check for $10 arrived from Blue Shield. Realizing that the payment was according to plan, the surgeon accepted it. And the radiologist was relieved of the sense of obligation that usually colors the professional-courtesy relationship.

An unusual story? Not nowadays. It seems that more and more medical men are weary of giving bottles of Scotch and objets d'art in recognition of major medical services from their colleagues. They feel that the whole concept of professional courtesy is awkward for both the giver and the recipient. [MORE ▶

Conservative therapy in hypertension can be made more effective



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As a result, doctors in many areas are taking out Blue Shield policies that cover all in-hospital medical and surgical care, as well as some outpatient work, for themselves and their families. Iowa already has several groups of doctors with such policies. About 10 per cent of Connecticut's M.D.s now have Blue Shield coverage. Manhattan and Brooklyn practitioners are in the process of getting it. Medical societies all over the country are considering it for their members.

There's still opposition, of course. Many a physician maintains that it's an honor to treat a fellow M.D. or his family, and that it's an insult to offer or accept payment for such service. He insists that health insurance isn't necessary. And besides, adds an occasional nay-sayer, Blue Shield's fee schedule is unrealistic, anyway.

Mercer County, N.J., is one of a number of counties in which most doctors have disregarded such arguments and bought Blue Shield policies. Here's the story of how the group there got started, and of what it has meant to M.D.-subscribers:

The idea for Blue Cross-Blue Shield coverage first popped up in the Mercer County Medical Society in 1948. Its originator was Dr. John F. Johnson, a surgeon. He was new to Trenton; he had five children who needed more-than-occasional medical care; and he disliked imposing on colleagues he hardly knew.

His proposal gained little ground at first. The doctors more or less pigeonholed it (they thought) by appointing a special committee to study the matter.

Dr. Johnson was named to head the committee. This gave him a good chance to discuss the idea with his colleagues. But most local doctors seemed apathetic to health insurance for themselves.

Some of them believed so strongly in professional courtesy as to be unable to accept an alternative. Others thought Blue Cross a good idea, but could see no need for Blue Shield.

Opposition Crumbles

Blue Shield gradually found supporters, however. And slowly the committee members began to make progress. They were particularly successful with young doctors who had large families. By 1951, they had lined up 145 of the society's 280 members—just enough to arrange for a group plan of their own.

Then came the biggest headache: a deluge of paperwork. The Mercer County society had no office staff that could handle the administrative details and collect premiums. So, in the beginning, Dr. Johnson and his fellow committee members handled such jobs themselves.

Before long, they were relieved of the task: The Trenton Banking Company agreed to administer the policies at an annual charge of $5 per subscriber. That freed the plan's proponents for the job of recruiting new subscribers. [MORE ▶

Since then, Mercer County's Blue Shield plan has been adding M.D. members steadily. It has made an average gain of eighteen doctors a year during the past four years. And today 216 of the society's 325 members have society-sponsored coverage.

Just what does the insurance provide? Quite simply, it pays for all in-hospital medical and surgical care for doctors and their dependents, plus some out-patient treatment. It's technically an indemnity plan; but Mercer County doctors accept the Blue Shield fee as full payment in all cases involving other doctors.

One local physician estimates that the insurance takes care of about half of the medical bills he used to "pay" with silverware or books. Dr. Johnson says it pays for nearly three-quarters of the services that he'd otherwise acknowledge with token gifts. And both doctors believe that other physicians may get even greater value out of the insurance.

What about the services Blue Shield *doesn't* take care of—the minor home and office visits? Apparently, they're no problem. The Mercer County doctors say they don't mind accepting professional courtesy in such cases, when necessary.

"The important thing," says Dr. Johnson, "is that Blue Shield takes care of the *big* obligations. They're the ones that used to embarrass us."

[MORE ▶

Does the plan help doctors in other ways? "It certainly does," he answers. For one thing, it gives them a freer choice of physicians, since they no longer hesitate to employ colleagues to whom they rarely refer patients. For another, it means an actual saving of money. (Annual cost for a doctor with wife and children: $46.08.)

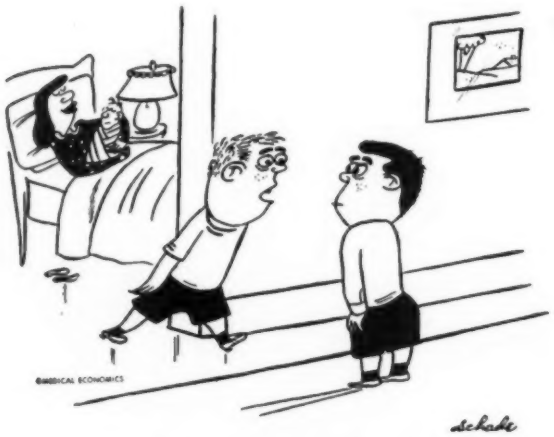
Says another M.D.: "Eight or ten token gifts a year used to cost me more than my current Blue Shield premium."

Can interested doctors elsewhere pick up some practical tips from the Mercer County experience? Trenton doctors point out three facts to consider, if you'd like to see a similar plan adopted in your area:

1. The idea has a better chance of acceptance in good-sized cities than in small communities. Metropolitan doctors are less likely to know one another well. Thus they're more hesitant about taking up a colleague's time.

2. For much the same reason, doctors who are new to communities are especially amenable to the idea. So, too, are physicians with a number of children. These are the men to set the plan in motion.

3. Most other physicians have to be sold on the idea. So a handful of doctors must devote a lot of free time to this project. But if they stick to their guns, they can usually succeed. That, at least, is the story in places like Mercer County. END



"I guess he's gonna stay. He's got his hat off."

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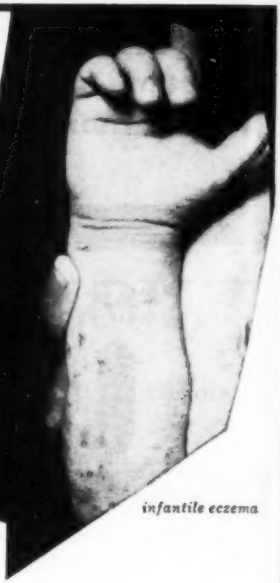

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*". . . secondary infection with pustulation often follow scratching which is induced by the intense itching." Nelson, W. E.: Textbook of Pediatrics, ed. 5, Philadelphia, W. B. Saunders Company, 1950, p. 1516.

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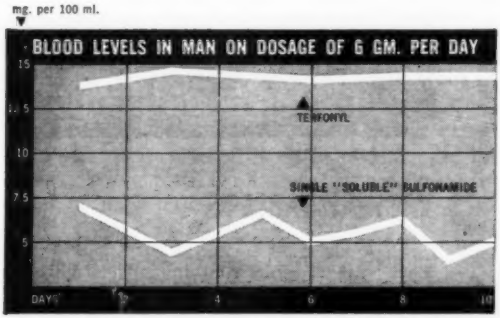

– After Lehr, D., Modern Med. 23:111 (Jan. 15) 1955.

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SQUIBB

Licensure: It's a Mess!

[CONTINUED FROM 100]

state medical society officers dominate the board. In seventeen jurisdictions, the Governor *must* appoint on the basis of medical society recommendations.

Obviously, your licensing fate is often in the hands of medical politicians who owe their position to the doctors with whom you propose to compete.

You can see, as a total result of all the above, that the present system of licensing physicians in the United States results in many discrepancies and inequities. These may leave you, too, confused if *not* amused.

Plenty of Paradoxes

You may observe some of the paradoxes yourself if you have time to dig into the annual issues of the Journal A.M.A. that include state board statistics. Here the facts and figures are laid out in massive array. But the data are so complex that pertinent points may be lost to view. Let's uncover a few right here:

In 1954, 6,125 American-trained candidates were examined by the fifty-four state and territorial boards. The failures totaled 257, or 4 per cent. Where were they? Largely, in Florida, Texas, New York, and Illinois, with a sprinkling in California, Connecticut, Maryland, New Hampshire, Vermont, and Oregon.

Some specific figures:

¶ New York flunked 14 per cent of the graduates from the state's nine medical schools, and nearly 30 per cent of those from elsewhere.

¶ Illinois knocked off 18 per cent of the out-of-state graduates, and over 4 per cent of those from its own five medical schools.

¶ Texas appeared far less proud of its own than you'd expect. Its state board passed 298 candidates from the three Texas schools and failed thirty-seven, or 11 per cent. In contrast, it let in forty-nine of fifty strangers to those medical parts, failing only 2 per cent.

¶ Florida is in a class by itself. It was responsible for failing more American-trained doctors in 1954 than *all other states combined*. Some 427 doctors passed the Florida examination; but 139, or 24 per cent, didn't make it.

¶ California, another happy hunting ground, was surprisingly liberal in comparison. Its board smiled warmly on the homegrown doctors, passing 268 and failing only one. But it also passed 164 out-of-state men, while failing only five.

No Failures Here

On the other hand, the record as of Jan. 1, 1955, showed six states in marked contrast to the treat-'em-rough areas: Kentucky, Minnesota, Montana, Tennessee, Washington, and Wyoming hadn't failed a single man in six years.

Twenty state boards pass *all* the graduates from medical schools

within the state. It's virtually automatic.

About a half-dozen others rarely flunk an in-state graduate. And most of these are equally easy on out-of-state candidates.

Reasonable States

Some states are eminently reasonable, wherever the applicant comes from. Missouri and Minnesota, to cite two, have their own medical schools; but they license almost as many doctors from outside as inside the state.

It's clear that some boards do a good job of easing the burden on you from conflicts of the law. But a few others control the supply of doctors by misusing an examination legally intended for the purpose of protecting the public.

Look at the situation from the standpoint of how graduates from various medical schools do before state boards, and you'll see how unfair it is. Either that, or you'll have to assume that the A.M.A. is approving some medical schools it shouldn't.

The Trouble With Boston

Why, for instance, did Boston University graduates have a 33.3 per cent failure rate in state board examinations in 1954? Or N.Y.U., 15.5 per cent? Or the Medical College of Georgia, 11.5 per cent? Or Georgia's Emory University, 8.1 per cent?

Why, conversely, did the graduates of thirteen schools have a 0.0 failure rate? These ranged from Albany Medical College and Chicago Medical School to the Universities of Washington and Utah. Surprisingly, not one of the historically great medical schools of the East was among them.

Before you write off Boston or N.Y.U. as poor medical schools, note where the failures occured: *Florida*. Nine Boston University men took the boards in 1954. Three of them went down to try it under the palms —and three failed. There's your 33.3 per cent.

Florida Flunks 'em

N.Y.U. and the two Georgia medical schools likewise took their beatings in Florida. The Augusta school sent twenty doctors across the state line; and Florida sent ten of them back.

Half a century ago, when the A.M.A. was cleaning out the diploma mills, one index for measuring a medical school was the performance of its graduates in state boards. Today that's no longer a measure of the medical schools, but only of the variability in treatment you may expect when you take a state board examination.

Would you think, for instance, that Louisiana State University medical graduates could do consistently better on licensing examinations than those from Harvard, Pennsylvania, Johns Hopkins, and Columbia?

They do, if the 1954 figures are taken at their face value. The only

L.S.U. man to fail his state boards that year was one who went to Florida.

Harvard Men, Too

Several Harvard graduates, on the other hand, flunked—though Harvard *was* able to put eleven of twelve starters over the Great Medical Barrier Reef into Florida.

Dr. Russell L. Cecil of New York, author of the classic "Textbook of Medicine," has made it, too. Contrary to an impudent legend of some duration among medical students and internes, he *did* get a license when he went to Florida.

"I passed with flying colors," Dr. Cecil reports.

But you, the average practitioner, aren't Dr. Cecil. You aren't a pariah either. It would seem that you ought to be able to practice where you please. It would only *seem* so, however—because you can't.

You're Not Wanted

You may have been licensed for forty years. You may have thought you lived in a free country. Yet, suddenly, you're not wanted. What have you done wrong? You've tried to cross a state line!

There's only one way to clean up the state licensure mess: A valid, fair, equal, and uniform system of examining and licensing *all* doctors must be found. END

invitation to asthma?

not necessarily . . .

Tedral, taken at the first sign of attack, often forestalls severe symptoms.

relief in minutes . . . Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

for 4 full hours . . . Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

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in boxes of 24, 120 and 1000 tablets

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I'm a Doctor's Husband

[CONTINUED FROM 134]

sound medical knowledge through cohabitation with an M.D.; but I *do* know something of what goes on in local medical affairs. My wife always tells me about the interesting X-Y-Z case she's working on (she never mentions names, and I don't ask). I also enjoy reading her medical journals, including MEDICAL ECONOMICS.

Oh, yes: As a doctor's husband, I'm eligible for professional courtesy. And I avail myself of it. After all, a guy in my shoes deserves *some* breaks.

Actually, I haven't much cause for grumbling. And I'm heartened by the fact that, in our area, I happen not to be the only man married to a doctor. A friend of mine is the husband of a woman anesthesiologist in a neighboring town.

We two husbands often joke about not having been invited to join the auxiliary of the county medical society. Right now, we are thinking of starting our own men's auxiliary. If that works out right, we may eventually try to set it up on a national scale and charge very substantial membership fees. Proceeds could be most advantageously used, we both feel, to defray baby-sitter charges. END

He Put His Industrial Practice on Wheels

[CONTINUED FROM 128]

trailer-truck practice is only one of three remunerative medical enterprises he now runs. The other two:

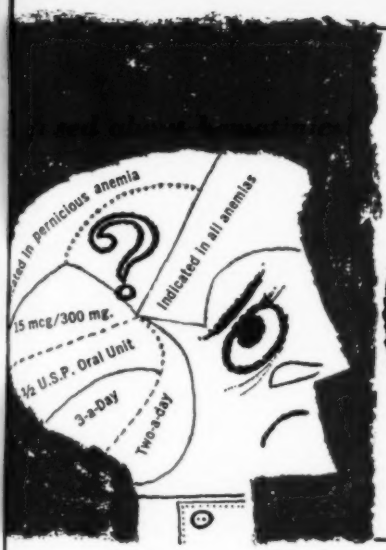
1. An in-plant medical service that undertakes to staff, equip, and organize any company's medical department.

2. A special health-vacation program for business and industrial executives. The doctor provides periodic medical examinations (with a built-in vacation) for about 400 executives a year. Examinations are done at his modern, fully equipped clinic in Asheville.

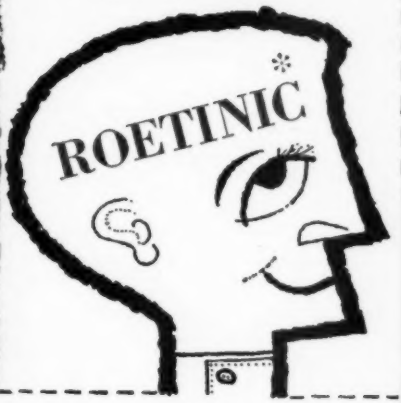
In connection with the health-vacation project, he recently bought The Manor, a resort hotel in Asheville. He also owns a restaurant concession on the top of near-by Mount Mitchell. And to help him and his staff shuttle between these enterprises, he some time ago set up his own two-plane airline.

Logan Robertson is nothing if not a highly mobile man. END

"He decided you weren't going to make it. So he took a home remedy."



just remember...



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Intrinsic Factor-Vitamin B_{12} Concentrate	1 U.S.P. Oral Unit
Folic Acid	2 mg.
Ferrous Sulfate, Exsiccated	400 mg.
Ascorbic Acid (C)	100 mg.
Molybdenum Oxide (as the Trioxide)	1.5 mg.
Cobalt (as the Gluconate)	0.5 mg.
Copper (as the Gluconate)	0.5 mg.
Manganese (as the Gluconate)	0.5 mg.
Zinc (as the Gluconate)	0.5 mg.

Supplied: Bottles of 30 and 100 soft, soluble capsules. On your prescription only.

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one dosage: ***One capsule daily for all treatable anemias...***

one name: **ROETINIC***

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Chicago 11, Illinois

*Trademark

Ewing to Hobby To Folsom

[CONTINUED FROM 112]

initiative to provide for himself. Those fears have proved groundless. The fact is that during this period there has been a great increase in all forms of individual savings. There has also been a striking and rapid growth in pension plans sponsored by employers."

What about health insurance? In this field, you can anticipate little trouble from the new Secretary. His efforts are likely to be much in line with the desires of America's doctors.

Reinsurance Remnant

Reinsurance for private companies' experiments in extending medical benefits?

Mrs. Hobby's successor can't very well knock it. But he reveals an inclination to "take a long, close look at it." He's aware that neither Congress, nor the insurance industry, nor the A.M.A., nor even the jaded proponents of compulsory health insurance are particularly interested in it.

All in all, Mr. Folsom appears to have much more to offer doctors than did either Mr. Ewing or Mrs. Hobby. Quiet, able, and cautious, he has already shown that he's also accessible. And he's opposed to public fireworks: He'd rather work for his conception of the general good behind the scenes than court publicity through a flood of propaganda.

He thinks the polio program is now back on the track. But all he'll say about Mrs. Hobby's troubles is: "I expect to have my own." This seems a safe prediction. After all, he *is* surrounded by three great pressure groups—health, education, and welfare.

Never Met Him

As of a month ago, he had not yet named his Special Assistant for Health and Medical Affairs. But it was likely that he'd make his choice as objectively as he did when he picked his Under Secretary, 53-year-old Herold C. Hunt.

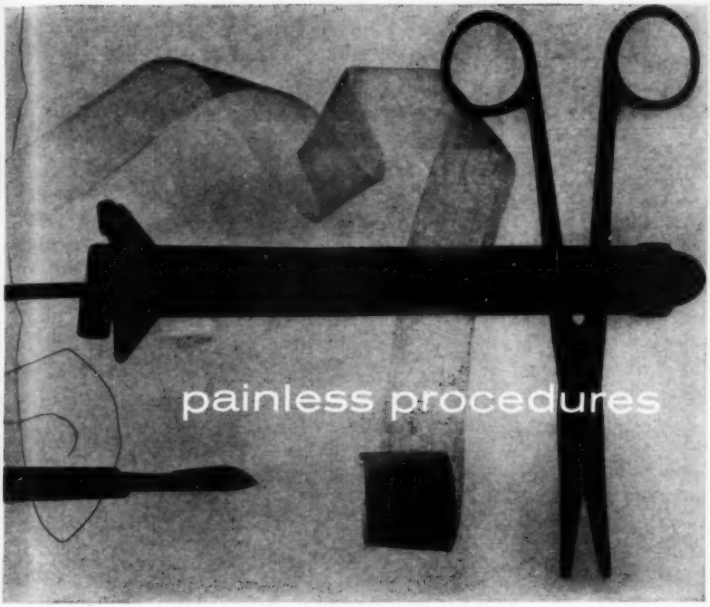
He chose Hunt on the basis of his record as Kansas City and Chicago superintendent of schools. The Secretary had never met the man until he offered him the job.

Himself 62, Marion B. Folsom told me he was searching for an intelligent, experienced, younger physician able to devote full time to the $15,000-a-year post.

No Elders Wanted

He recognized, he added, that few brilliant and successful doctors in their prime could afford the reduction in income. But he didn't want one of the medical profession's elder statesmen.

It would appear that, however amiable, Secretary Folsom is still an independent at heart. END



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News

[CONTINUED FROM 22]

teen-week trial, twenty-five out-of-state hospital and medical spokesmen came to Des Moines to testify for the physicians.

At the end, Judge C. Edwin Moore concluded:

"Under the Iowa law, the privilege of practicing medicine is a personal one requiring qualifications which cannot be met by a corporation. The provisions of Iowa law do not grant hospitals any right to practice medicine by the operation of pathology and X-ray laboratories in the manner shown by the evidence [in this case]."

He added: "It is the opinion of the court that the furnishing of [such] services to the patients in the hospitals can be worked out on the local level and within the law."

The Iowa trial has been watched with interest by doctors and hospital officials the country over. Though the question has been argued elsewhere, this is the first time a court has ruled so specifically on it. A month ago, the hospital association decided to appeal the case to the State Supreme Court.

Unless Judge Moore's decision is reversed, it may well set a pattern for other states. This would mean that the physician must either bill the patient directly for pathological and X-ray services, or designate the hospital as a collecting agent. (But if the hospital does the billing, its role as collecting agent must be made clear to the patient. And the doctor's name and fee must appear on the statement sent by the hospital.)

G.P.s Claim a Right to Assist—and Be Paid

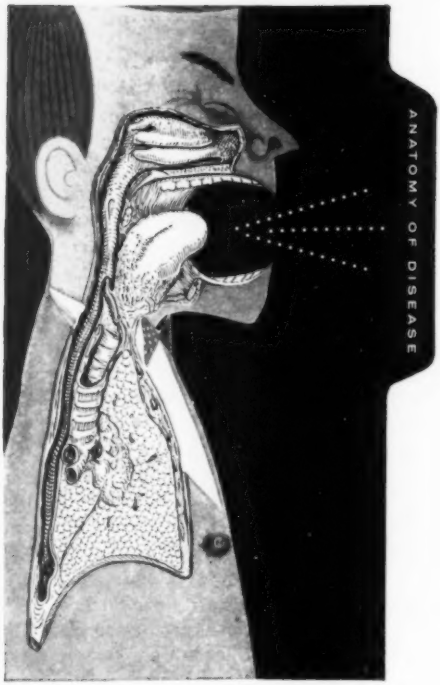
The case for G.P.-assistance at surgery has again been forcefully stated—this time in Milwaukee. Here's the story:

To preclude any possibility of fee splitting on its staff, St. Joseph's Hospital recently considered adopting the so-called Columbus Plan (under which staff privileges are granted only to physicians who agree to a regular audit of their financial records). Before putting the plan into effect, the hospital's executive committee decided it needed an answer to a basic question: What, exactly, constitutes fee splitting?

So the committee sent off a letter to the American Academy of General Practice, stating its problem and asking for advice. The statement was illuminating, the advice even more so.

In its inquiry, the Milwaukee institution explained that there were conflicting interpretations of "what constitutes proper and ethical conduct. This difference of opinion is best illustrated by the following example:

"Dr. A, a general practitioner, . . . visited the patient at home, sent her



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Dihydrocodeinone Bitartrate Warning—may be habit-forming	1/8 gr.
Potassium Guaiacol Sulfonate, N.F.	8 gr.
Sodium Citrate, U.S.P.	13.2 gr.
Citric Acid, U.S.P.	2 gr.
Prophenpyridamine Maleate (10 mg./teasp., 5 cc. medicinal)	1 gr.
Chloroform, U.S.P.	2 minims
Methylparaben, U.S.P.	0.1%
Flavor, sweetening, aroma, vehicle	

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to the hospital, and after a diagnostic work-up decided she had an acute appendicitis. He called Dr. C, a surgeon, in consultation. Dr. C, after his own work-up, . . . performed an appendectomy. Dr. A saw the patient postoperatively in the hospital at the patient's request."

Since Dr. A hadn't assisted at the operation, wrote the committee, was he entitled to any part of the Blue Shield fee? Some of St. Joseph's doctors insisted he was; others maintained that Blue Shield covers only surgical costs.

Or suppose, the letter went on, that Dr. A *did* assist Dr. C, "even though adequate resident and interne help is available . . . The first group argues that since he is not needed in the operating room, he does not facilitate the operation. He is, therefore, not entitled to a portion of the Blue Shield fee." (The other group, of course, favored fee apportionment.)

The A. A. G. P. Committee on Prepaid Voluntary Medical Care minced no words in its reply. The committee "forcibly restated" its position that "the surgical fee [must be prorated] when two or more physicians have participated in the care of the patient." And it added:

"No one should be permitted to get by with the sophistry that this is fee splitting. It isn't. It is the division of the total fee into its proper component parts. The cutting operation is only a small part of the total expense . . . Blue Shield does not insure the patient against the costs of the surgeon's fee. It insures the patient against the considerable costs he incurs in connection with an illness requiring surgery . . .

"The adoption of the so-called Columbus plan will not solve the problem of dishonesty within your staff or any other hospital staff. It would enact a police state . . . Morality and honesty stem from the heart and not from . . . some kind of a Medical Volstead Act."

As for the second problem, "it is presumptuous to believe that . . . an interne or resident would supplant the family doctor at the time of surgery. A wise and conscientious surgeon would welcome the presence of the attending physician . . . It has little to do with the proration of the fee. It has everything to do with the welfare of the patient."

Private Hospitals Get an Orchid

Here's a good word for the proprietary hospitals—long a favorite whipping boy. "The leaders of medicine will do well if they pay greater attention" to such institutions, says Dr. Irving J. Sands, writing in the bulletin of the Kings County (N.Y.) medical society. The profit-making hospital, he observes, offers two unique services:

1. It provides the best possible care for the many patients who "do not wish their insides exposed to the public."

[MORE ▶

2. It gives staff appointments to doctors who can't get into nonprofit hospitals. (This, says Dr. Sands, is a boon to the young man just starting in practice; to the doctor who's excluded from the nonprofit institution because he isn't a certified specialist; and to the older doctor who's been asked to retire from a nonprofit hospital.)

Panel Plan Woos M.D.s —And Gets Snubbed

It's apparently becoming harder for closed-panel plans to hire staff doctors. The Cooperative Health Insurance Plan of Milwaukee, which set out to get forty physicians for two projected groups, admitted recently that it had not been too successful.

In a move to attract Wisconsin physicians, the plan sent a circular letter to every licensed medical man in the state. Among other things, the letter promised the following benefits to each successful applicant:

¶ Fifteen per cent less overhead;

¶ "A guaranteed, steady income," regardless of work loads;

¶ Complete solution of business problems;

¶ More time off (free week-ends, paid vacations, etc.);

¶ "Better protection against patients' unreasonable demands."

Sound enticing? Maybe; but few

DR. CHARLES E. HORTON

He found quacks by the dozen

doctors seemed in a hurry to sign up. Says a spokesman for C.H.I.P.—which is co-chaired by Dr. George Baehr, president of the Health Insurance Plan of Greater New York, and Harvard's Dr. James Howard Means: "The main reason why doctors are reluctant seems to be the hostility of the county medical society."

Radiologists in Private Practice Prosper

How are young radiologists who strike out for themselves faring these days? To get an answer, the American College of Radiology conducted a survey of some 100 radiologists who'd begun office practice (as opposed to hospital practice) within the past five years. And it found that they're apparently doing fine.

They face problems, of course. Almost half of them plunged deeply into debt to set up their practices; one out of three is worried by competition from hospitals; many are concerned because of the difficulty of getting referrals.

But they seem to value their "independence" and to be confident of the future. Although 85 per cent of them have hospital affiliations, 67 per cent claim they could make a go of it on their office practice alone.

Comments one young respondent: It's only fear of going into debt that prevents more radiologists from launching out for themselves. Yet, he adds, "if a man gets good training and is willing to really work, . . . he cannot fail."

Quack Cancer Cures Probed by M.D.s

At least sixty-two cancer "cures" are now being marketed in the U.S., reports a Duke University investigation team headed by Dr. Charles E. Horton. The cost of such "cures" to the public, adds the American Cancer Society, is $10 million a year and hundreds of unnecessary deaths.

Such common products as distilled water, vinegar, fig leaves, and just plain fat were among the "remedies" dredged up by the Duke investigators. But they point out that charlatanism has also geared itself to the

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sulfadiazine	167 mg.
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machine age. Among the profitable contraptions discovered were these:

¶ An "ocillocast" that makes diagnoses from patients' signatures, many of which are sent in by mail. This Rube Goldberg device (it has clanking gears and ringing bells) is popular in California, where scores of the unwary have been mulcted out of as much as $600 apiece.

¶ A "uranium tunnel" in which hundreds of patients have been treated "radioactivily." Investigators used a Geiger counter to determine the amount of radioactivity in one such tunnel in Wisconsin; it approximated "the fallout from a firefly."

¶ A "radionic machine" that sparks, buzzes, and clicks. From the amount of racket the machine produces, the operator claims to be able both to diagnose the seriousness of his patient's cancer and to determine the best way of treating it.

A Radio in Your Office Called a Defense Need

Got a radio in your office? If not, better get one. That's the lesson of a recent civil defense test in Minneapolis.

In the drill, it was presumed that a bomb with the explosive force of a million tons of TNT had been dropped on the city. The resultant ring of major destruction was seven miles across; and "moderate" damage stretched even farther. Nearly all the city's major hospitals and office buildings, and the homes of many physicians, were assumed to be devastated.

Should a real emergency of this kind arise, says Dr. Carl W. Waldron, co-chairman of the Minneapolis Civil Defense Medical Committee, "the importance of *warning* to make possible effective evacuation cannot be overemphasized." His advice to doctors, as printed in the Hennepin County medical bulletin:

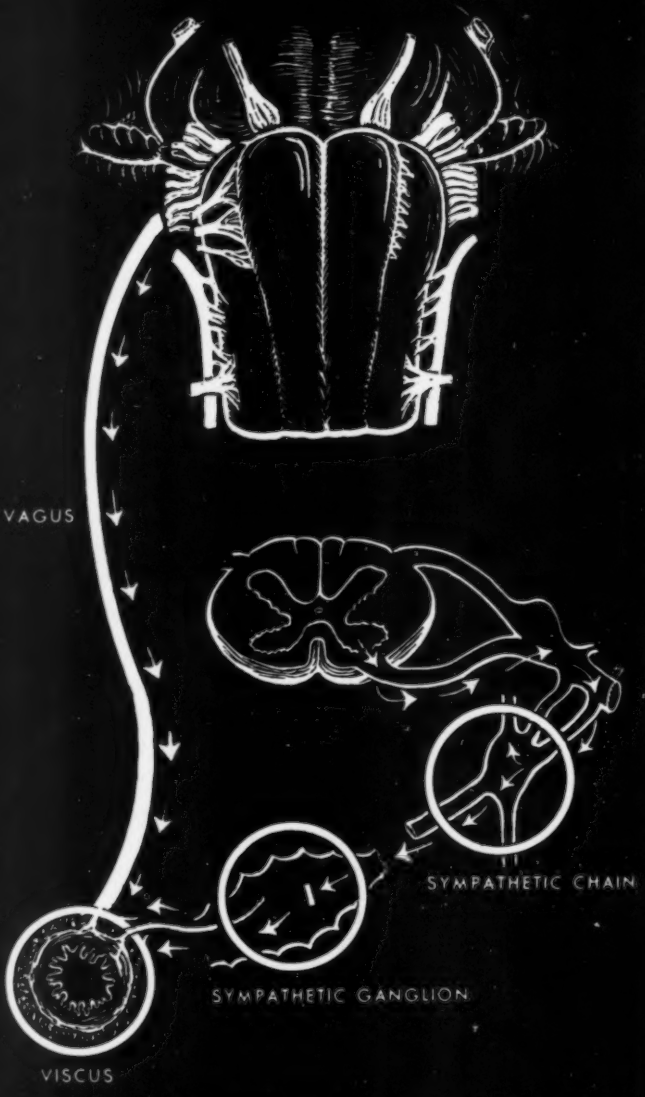
¶ In time of danger, keep your radio *on*, whether you're in your office, at home, or in your car. Have battery-operated sets in your office and home in case the power fails. Radio warnings and instructions will probably begin twenty to thirty minutes before the sirens go. So you'll get the news of an attack earlier than you otherwise would.

¶ If you have two cars, let your wife use one to take the family to a safe place. You can drive the other car directly to your assigned hospital zone assembly building.

¶ If you have only one car, go home first. Then, after you've taken your family to safety, return as soon as possible to your hospital zone assembly.

Company Sets Up Giant Major Medical Plan

The concept of major medical expense insurance has now become a solid fact for one large segment of the nation's workers. General Electric's new welfare program provides its 200,000 employes with what



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Roback and Beal[2] found that Pro-Banthine orally was an "inhibitor of spontaneous and histamine-stimulated gastric secretion" which "resulted in marked and prolonged inhibition of the motility of the stomach, jejunum, and colon. . . ."

Therapy with Pro-Banthine is remarkably free from reactions associated with parasympathetic inhibition. Dryness of the mouth and blurred vision are much less common with Pro-Banthine than with any other potent anticholinergic agent.

In Roback and Beal's[2] series "Side effects were almost entirely absent in single doses of 30 or 40 mg. . . ."

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For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.

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1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.
2. Roback, R. A., and Beal, J. M.: Gastroenterology *25*:24 (Sept.) 1953.

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The company foots the bill for two-thirds of its workers' protection. The employe himself must pay only 0.9 per cent of his annual earnings for his individual protection. For another 2 per cent of each year's pay (up to $5,000), he gets coverage for his dependents.

Hawaiian Medical Men Speak for Osteopaths

Last June, you may remember, the A.M.A. voted down a proposal that would have allowed medical men to teach in schools of osteopathy. But some M.D.s have refused to accept the A.M.A. decision as final. Witness a recent editorial that appeared in

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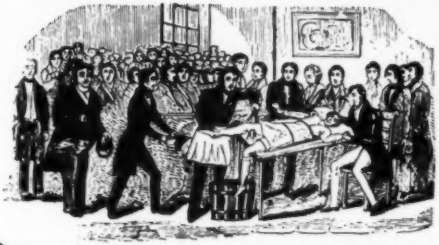

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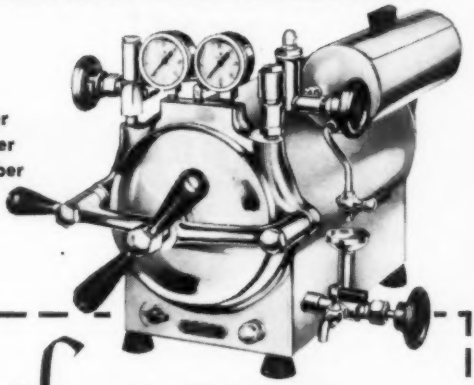

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great
AUREM

No matter how you measure it, AUREOMYCIN* Chlortetracycline can claim a distinguished record: in terms of published clinical trials—there are more than 8,000; as for actual doses administered—the figure is more than a *billion*.

But the most significant fact is told by time. For eight years, AUREOMYCIN has been in daily use, repeatedly employed by thousands of physicians throughout the world. Again and again, it has proved to be a reliable broad-spectrum antibiotic: well-tolerated, prompt in action, effective in controlling many kinds of infection.

A convenient dosage form for every medical requirement

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Now Available:

AUREOMYCIN SF Capsules, 250 mg.

Chlortetracycline with Stress Formula Vitamins.

For Patients with Prolonged Illness AUREOMYCIN SF combines effective antibiotic action with Stress Formula vitamin supplementation to shorten convalescence and hasten recovery. One capsule, q.i.d. supplies one gram of AUREOMYCIN, and B complex, C and K vitamins in the Stress Formula suggested by the National Research Council. AUREOMYCIN SF Capsules are dry-filled and sealed, contain no oils or paste.

Each capsule contains:

AUREOMYCIN Chlortetracycline	250 mg.
Ascorbic Acid (C)	75 mg.
Thiamine Mononitrate (B_1)	2.5 mg.
Riboflavin (B_2)	2.5 mg.
Niacinamide	25 mg.
Pyridoxine (B_6)	0.5 mg.
Folic Acid	0.375 mg.
Calcium Pantothenate	5 mg.
Vitamin K (Menadione)	0.5 mg.
Vitamin B_{12}	1 mcgm.

THE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* PEARL RIVER, NEW YORK

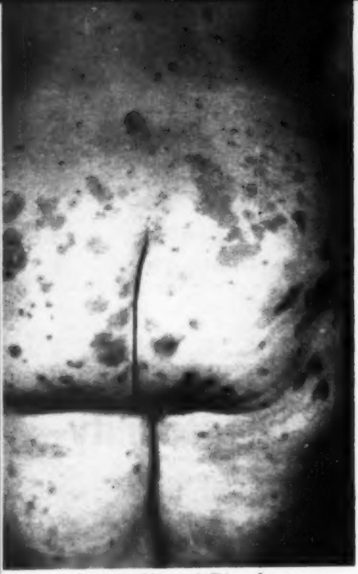
Lederle

the journal of the Hawaii Medical Association:

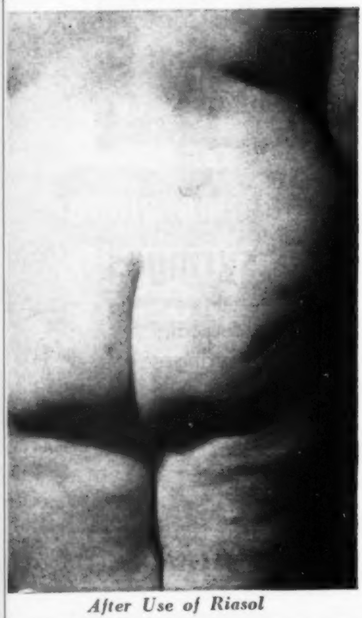
Osteopaths, the editorial points out, treat some 7 per cent of the American people. Their schools offer an "intensive four-year curriculum, which includes all of the subjects taught in orthodox schools of medicine."

But, insists the journal, they need help in improving their teaching programs—and, as a result, their care of the sick:

"It is as much the responsibility of the A.M.A. to try to improve the quality of that care, by improving the osteopathic schools' teaching facilities . . . as it was fifty or one hundred years ago for us to try to improve the quality of training in our own schools of allopathic medicine. To shirk this responsibility . . . is unworthy of our professional ideals and ethical standards. The A.M.A. has, in its care to avoid any association with cultism, done a disservice to the public whose well-being it professes to place above all other considerations." END



Before Use of Riasol



After Use of Riasol

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In a statistical analysis of cases of psoriasis treated with RIASOL, the cutaneous patches cleared up or were greatly improved in an average period of 7.6 weeks. This is an outstanding record of achievement.

RIASOL has been used extensively by dermatologists and research physicians. Therapeutic results have been evaluated and recorded by hundreds of comparison clinical photographs.

In a large series of controlled cases, the cutaneous lesions disappeared, or were greatly ameliorated in 76% of cases under treatment with RIASOL. This medication reaches and helps alter the psoriatic lesions located in the deeper epidermal layers.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

Ethically promoted RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.

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Test RIASOL Yourself

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RIASOL FOR PSORIASIS

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	8 oz. EGGNOG*	8 oz. MERITENE MILK SHAKE
Protein	14.6 gm.	17.9 gm.
Fat	15.0 gm.	9.5 gm.
Carbohydrate	24.7 gm.	28.6 gm.
Iron	1.5 mg.	4.46 mg.
Calcium	.31 gm.	.58 gm.
Phosphorus	.33 gm.	.46 gm.
Vitamin A	940 I.U.	2380 I.U.
Thiamine	.14 mg.	.77 mg.
Riboflavin	.56 mg.	1.64 mg.
Ascorbic Acid	3.0 mg.	23.7 mg.
Vitamin D	31 I.U.	161 I.U.
Cholesterol	299 mg.	38.4 mg.
Calories	291 mg.	270

Meritene Milk Shake costs 1 to 4¢ less per serving than eggnog

*Nutritive value of Eggnog from Bowes and Church, 7th Ed. 1951.

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Available at all drugstores in plain or chocolate flavors. 1 lb. can—$1.69; 5 lb. can—$7.74.

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True pharmacodynamic synergism enhances the therapeutic potency of each of the 4 forms available for discriminating prescription:

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Codeine phosphate (¼ gr.) . . . . 16.2 mg.

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PHENAPHEN
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Codeine phosphate (½ gr.) . . . . 32.4 mg.

Phenaphen No. 4
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The basic phenaphen formula plus
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Memo

FROM THE PUBLISHER

Who We Are

What sort of people put out MEDICAL ECONOMICS? Perhaps you've wondered as you've skimmed past the names listed on our masthead (page 9). If so, you may like to read a brief collective profile of the eighteen people who make up our editorial staff.

They're not economists—although they draw much of their material from such sources. With one exception, they're not medical men—although they spend most of their time working with doctors. Instead, they are professional magazine people. It's their job to ask the right questions, get the right answers, and put them into articles you'll want to read.

Are they properly prepared for this job? Let's have a closer look:

If you took our eighteen editors together, you'd wind up with a pretty fair pool of experience. The resulting composite would have gone to college for eighty-five years, picking up almost a score of B.A.s, plus five M.A.s and two Ph.D.s.

He'd be a graduate three times over of Yale, and would have attended such other institutions as Williams (twice), Oberlin, Harvard, Duke, and Michigan.

This same mythical person has spent 199 years in journalism, eighty-four of them on MEDICAL ECONOMICS. In his youth he edited the Journal of the History of Medicine, and later he was on the staff of the Reader's Digest.

He has also been a staffer on the Washington Star and the Detroit Free Press, on New York's Daily News, and even on the Birmingham (Mich.) Eccentric. He's been United Nations press officer in Indonesia, archivist of the Welch Medical Library at Johns Hopkins, and an editor of the New Yorker.

Once he helped a Supreme Court justice write articles for the weekly press, and he has often profiled doctors for the Saturday Evening Post.

In the course of his long life (63 last birthday), he's had his full share of adventure. He grew up abroad because his father was a diplomat. During his thirty-six years of military service he fought in two wars—but he came a lot closer to getting killed while reporting a small Guatemalan revolution in 1949.

So far this composite editor has been married sixteen times. He's engaged to a seventeenth girl right now. Nearly all his wives read MEDICAL ECONOMICS, and nearly all complain that he's away from home too much.

But that, he says, is the price of being a MEDICAL ECONOMICS editor. "Suppose I were a doctor instead?" he asks—and his wives know just what he means. —LANSING CHAPMAN